Schiavoni, Richard Cordray, Dennis Kucinich and Bill O'Neill debated before a standing room only crowd in Cleveland Heights, where they articulated their visions for Ohio. With Ivan Conard of the Young Black Dems, our director Amy Hanauer moderated the debate, pushing for straight answers to questions about jobs, education, clean energy and more. You can stream video of the event here, or listen to ideastream's coverage here. Early voting is already under way, and Primary Day is May 8th. See you at the polls!

Platform in Progress: In this crucial election year, Ohio needs candidates who embrace a research-based progressive platform. *A Winning Economic Agenda for Ohio's Working Families* provides that. The report, a collaboration with our friends at Innovation Ohio, proposes investing in infrastructure, manufacturing, childcare and education. It calls to restore adequate taxes, protect workers, and reduce discrimination, addiction and incarceration. And it is a living document: We'll fold in feedback from people across the state, gathered at public forums throughout the summer. Huge thanks to our Hannah Halbert and IO's Terra Goodnight for doing the heavy lifting to get this report to press. The first forum is May 16th in Columbus. Stay tuned for details!

If there were any doubt: The Trump Tax law showers benefits on the most affluent Ohioans, while cutting the basics for the rest of us. Get the details in a new report from the Institute on Taxation and Economic Policy. Our Zach Schiller's Tax Day release, finds that middle-income Ohioans average an $800 cut, while the top one percent take home an additional $40,190. The result will be an estimated $1.9 trillion deficit explosion. To pay for it, the Trump administration and its allies in Congress plan to squeeze American workers and caregivers, blocking access to crucial safety net programs for millions.

SNAP works, new bill doesn't: To pay for these lavish tax cuts, the House Agriculture Committee passed the Farm Bill, which threatens

over 1.4 million Ohioans who need food assistance to get enough to eat. It erects needless barriers by expanding work requirements, stiffening penalties, and cutting off food aid for hungry Americans. Victoria Jackson's new report finds these measures fail to increase employment, don't help the economy, and leave millions of Americans hungrier. Contact your congress member now to resist this cruel, counterproductive bill.

What would you do with $9 billion?: Like other state spending, tax expenditures should have a purpose, and should be regularly evaluated to determine effectiveness. Last year's HB 9 established the Tax Expenditure Review Committee to do just that. Ohio spends $9 billion annually on these breaks. Zach recently testified, advocating careful analysis and regular reapproval of every tax expenditure, rather than allowing them to continue indefinitely. Contact your legislator if you can think of better ways than tax breaks to spend $9 billion.

Caitlin Johnson in the Policy Matters offices

Paid family leave: Communications Director Caitlin Johnson will have her first child in June! While we'll likely pressure her to bring the little guy in for a visit, we offer paid leave, and we plan to let her spend her first few months of motherhood bonding with her son and getting her bearings as a new mom. In her recent blog, Caitlin acknowledges how fortunate she is: Only 13% of American private sector workers have access to paid leave. Policy can fix this and Ohio leaders are stepping up: State Reps. Janine Boyd and Kristin Boggs, and State Sen. Charleta Tavares have proposed bills to create the Ohio Family and Medical Leave Insurance Program. **Check out the Ohio** Women's Public Policy Network's advocacy toolkit **for ways you can promote the bill.**

Sarah Silverman and Policy Matters: Comedian Sarah Silverman called out Amazon CEO Jeff Bezos on Twitter for his low pay of workers. Check out this video to see where those findings came from. Want the receipts? Check Zach's recent research on Amazon's exploitative practices.

Out and about: In the last two weeks, Amy moderated the Democratic governor's forum; Victoria moderated a panel on "Realizing education potential" at Case's Schubert Center for Child Studies; we co-hosted a screening of the documentary *Zero Weeks* with a panel discussion, moderated by Caitlin and featuring Representative Boyd and Max Gerboc from SEIU Local 1; Zach testified on tax expenditures; and Wendy testified on the sales tax exemption for oil and gas companies.

Coming up: On Saturday, the Coalition for Hispanic/Latino Issues and Progress holds its 23rd annual leadership conference, including A Community Conversation on the Status of the Hispanic/Latinx Community, with our Daniel Ortiz. Wendy Patton will appear on *In Focus with Mike Kallmeyer* to discuss Medicaid work requirements on Spectrum Cable channels 1311, 510, and 511, Sunday, April 29 at 10:30 and 11:30 am, and Monday at 7:30 am. Amanda Woodrum will

be on *Face the State with Scott Light* for a roundtable on health care and Medicaid on WBNS TV10 in Columbus Sunday, May 6th at 11:30 am. Cynthia Connolly will host a table top at Cleveland Public Theater's event *Station Hope* on May 5th as part of their *Activate Hope* installation, from 6:30-10:00 pm at St. John's. Tune in or join us at these great community conversations.

VIEW ONLINE

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STAY CONNECTED:

Alexander, Steven

From: Kaiser Health News <emails@kaiserhealthnews.org>
Sent: Friday, April 27, 2018 9:41 AM
To: Alexander, Steven
Subject: KHN Morning Briefing: April 27, 2018

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In This Edition:

17. Viewpoints: Here's Hoping Trump Finally Shows Care For Veterans' Health; GOP's War On The Poor Expands

From Kaiser Health News:

KAISER HEALTH NEWS ORIGINAL STORIES

1. Dissecting The Rhetoric Vs. Reality Of Trump's Tough Talk On Drug Prices

President Donald Trump's upcoming speech on drug prices comes after months of public comments and debate about tackling the issue. (Sarah Jane Tribble, 4/27)

2. Podcast: KHN's 'What The Health?' What's Next For The VA?

In this episode of KHN's "What the Health?" Julie Rovner of Kaiser Health News, Sarah Kliff of Vox.com, Anna Edney of Bloomberg News and Alice Ollstein of Talking Points Memo discuss the collapse of the nomination of White House physician Ronny Jackson to head the Department of Veterans Affairs. They also discuss new bipartisan congressional efforts to address the opioid epidemic. Plus, for extra credit, the panelists offer their favorite health policy stories of the week. (4/26)

3. Male OB-GYNs Are Rare. Is That A Problem?

Nationally, women outnumber men as specialists in obstetrics and gynecology — yet women remain underrepresented in leadership roles. Many OB-GYN patients say they prefer female doctors, as residency programs strive for diversity in race, ethnicity and even gender. (Alex Olgin, WFAE, 4/27)

4. Readers Weigh In On Vitamin Use And The Big Pharma-Patient Advocacy Connection

Kaiser Health News gives readers a chance to comment on a recent batch of stories. (4/27)

5. Political Cartoon: 'Heal Thyself?'

Kaiser Health News provides a fresh take on health policy developments with "Political Cartoon: 'Heal Thyself?'" by J.C. Duffy.

Here's today's health policy haiku:

PROPOSED RULE WOULD REQUIRE HOSPITALS TO POST PRICES

Price posting mandates
Will work not quite as well as
Consumer demand.

- Ernest R. Smith

If you have a health policy haiku to share, please Contact Us and let us know if you want us to include your name. Keep in mind that we give extra points if you link back to a KHN original story.

Summaries Of The News:

VETERANS' HEALTH CARE

6. Beyond The Theatrics Of VA Nomination Controversy Lies A Leaderless And Troubled Agency

Dr. Ronny Jackson withdrew his name as nominee to lead the Department of Veterans Affairs, leaving advocates worried about the chaos and risks ahead for the agency that serves 9 million military veterans and employs 350,000 workers. "Veterans are losing six different ways right now, from all directions, and it's discouragingly unclear why this

keeps happening or what might make it stop," said Joe Chenelly, national executive director for AMVETS.

Politico: 'Veterans Are Losing 6 Different Ways Right Now'
The implosion of Ronny Jackson's nomination to lead the Veterans Affairs Department may look like the Trump administration's drama of the moment, but it carries big consequences for 9 million veterans in a sprawling health care system with uneven results and a precarious future. Not only does the VA have no leader, the veteran health care community is divided between conservatives inclined to privatize much of veterans' care and those who want to invest more in fixing the current system. The impact can be seen across 170 medical centers and hundreds of clinics of varying quality that treat veterans who served in the U.S. military in every conflict since World War II. (Allen, 4/26)

Modern Healthcare: VA Choice Reforms Face Tight Timeline As Focus Turns To Trump's Next Nominee For Secretary
Amid the noise over Dr. Ronny Jackson withdrawing from consideration for secretary of Veterans Affairs, key lawmakers and stakeholders vow the long-stalled VA Choice reforms will move forward as planned even as the timeline grows shorter and the focus has shifted to finding the next nominee. The House VA Committee this week was supposed to debate the bipartisan agreement reached last month, but that has been postponed until early May, and not all parts of the deal are set in stone, according to aides close to talks. (Luthi, 4/26)

Boston Globe: Partners Among Hospital Systems Quietly Advising Trump On Improving VA
Leaders from the Mayo Clinic, Partners HealthCare, and other large hospital systems have been quietly advising the Trump administration on how to improve the Department of Veterans Affairs, the Mayo Clinic's chief executive said Thursday in Boston. (Dayal McCluskey, 4/26)

The New York Times: For Many, Life In Trump's Orbit Ends In A Crash Landing
Another day, another casualty. Or two. By the time the sun set Thursday, Dr. Ronny L. Jackson was a failed cabinet nominee whose life had been picked apart for public consumption, and Michael D. Cohen was back in court facing possible criminal prosecution. A ride on President Trump's bullet train can be thrilling, but it is often a

brutal journey that leaves some bloodied by the side of the tracks. In only 15 months in office, Mr. Trump has burned through a record number of advisers and associates who have found themselves in legal, professional or personal trouble, or even all three. (Baker and Haberman, 4/26)

The Washington Post: Ronny Jackson Withdraws As Trump's Nominee To Lead Veterans Affairs, But He Remains Under Scrutiny
Ronny L. Jackson's withdrawal from consideration to lead the Department of Veterans Affairs stanched an immediate political crisis for the Trump White House, but it sparked new questions over his future as the president's doctor and the fate of the embattled agency. Jackson announced Thursday morning that he was pulling out of the nomination process amid a mushrooming cloud of allegations over professional misconduct, leaving in limbo a sprawling federal bureaucracy serving 9 million military veterans that President Trump has called a top domestic priority. Yet even as Jackson strongly denied the charges against him, calling them "completely false and fabricated" in a defiant statement, his position as Trump's chief physician and a pending Navy promotion looked shaky. (Rein, Lamothe and Nakamura, 4/26)

Politico: 'Jon Poked The Bear': Tester Braces For Trump's Revenge
Jon Tester didn't intend to play a central role in taking down President Donald Trump's pick to lead the Veterans Affairs Department. Yet that's exactly what the Montana Democrat ended up doing. And now, Trump is coming after him. (Everett, 4/26)

Politico: The Cost Of Donald Trump's Deserted Government
Job vacancies are fast becoming a singular threat to President Donald Trump's administration, with a record number of openings that stretch from low-level appointments to the secretary's office at the Department of Veterans Affairs. While civil servants have stepped up to fill gaps, their power and influence is limited — and many senior career government workers have quit or retired since Trump took office, taking institutional knowledge with them. (Woellert, 4/27)

Kaiser Health News: Podcast: KHN's 'What The Health?' What's Next For The VA?
The Trump administration has withdrawn the nomination of White House physician Ronny Jackson to head the Department of Veterans Affairs after allegations surfaced about inappropriate handling of prescription drugs, issues with alcohol and difficulties

working with other White House medical unit staffers. It is unclear whom the White House will turn to next to take over the helm at the VA. (4/26)

HEALTH LAW

7. Coalition Of 20 Republican-Led States Suing Over Health Law Asks For Temporary Injunction

In its larger lawsuit, states led by Texas and Wisconsin argue that because Congress eliminated the tax penalty the health law is now unconstitutional.

The Associated Press: 20 States Seek To Block Obama's Health Care Law
Twenty Republican-led states are seeking to temporarily invalidate former President Barack Obama's health care law while their larger lawsuit against it proceeds. In a February suit, Texas and Wisconsin led a coalition arguing that the Affordable Care Act is no longer constitutional after the Republican-backed tax overhaul eliminated fines for not having health care coverage. Sixteen states with Democratic governors later sought to intervene. They suggested that Democratic attorneys general will have to defend the law because President Donald Trump's administration won't. (4/26)

Dallas Morning News: Paxton-Led Coalition In Pursuit Of Obamacare Repeal Seeks Injunction By Year's End
Attorney General Ken Paxton is urging a federal court to eliminate Affordable Care Act regulations in Texas before the end of the year. Paxton and Wisconsin Attorney General Brad Schimel are leading a 20-state coalition that sued in February, challenging the constitutionality of the law. On Thursday, the coalition asked the U.S. District Court for the Northern District of Texas to grant a preliminary injunction by Jan. 1, 2019. (Wang, 4/26)

In other health law news —

Modern Healthcare: CMS Extension Of Transitional Health Plans Could Ding ACA Market
The CMS has once again allowed insurers and states to renew so-called transitional health plans that pre-dated Affordable Care Act coverage requirements and that don't have to comply with those rules. State officials have the option to end these

"grandmothered" plans in the individual and small-group markets. But about three dozen states have allowed them to continue, even though experts say moving transitional plan enrollees into the ACA-regulated market likely would bring down premiums. (Meyer, 4/26)

Politico Pro: Health Care Industry Opposes Trump's Plans To Expand Short-Term Coverage
The health care industry is largely united in opposition to the Trump administration's efforts to expand short-term plans that don't meet the Affordable Care Act's coverage requirements. Groups representing insurers, hospitals, doctors and patients all offered strong criticism of the proposal in recent comments to CMS, warning that making it easier to purchase skimpier plans will siphon off healthier customers from Obamacare and further destabilize the law's wobbly marketplaces. (Demko, 4/26)

PHARMACEUTICALS

8. These Charities Are Meant To Help Patients Pay For Drugs. But Critics Say They're Just A Marketing Arm Of Pharma

The groups are being accused of driving up the cost of health care by masking the price of drugs and forcing higher costs on the insurance companies that pass them along to consumers and employers. Meanwhile, KHN dissects President Donald Trump's rhetoric over high drug costs.

USA Today: Drug Copay Assistance Keeps Patients Alive And Prices, Premiums High
Copayment assistance groups, created to help patients with the increasingly higher price of drugs to treat medical conditions, are under investigation by federal authorities for possibly skewing the cost of health care to favor drug companies. The probes, noted by several drug makers in their regulatory filings, are slowing contributions to at least two of these assistance groups, charities that sometimes pay top executives salaries of $300,000 or more. Critics of these groups, such as Patients for Affordable Drugs founder David Mitchell, say they drive up the cost of health care by masking the price of drugs and forcing higher costs on the insurance companies that pass them along to consumers and employers. (O'Donnell, Robinson, Alltucker and Freeman, 4/26)

Pre$cription For Power: Explore KHN's Database Investigating The Relationships Between Patient Advocacy Groups And Big Pharma

The Washington Post: Why Drug Companies See Rare-Disease Patients As Human Jackpots
The swelling attacks come on without warning. Loukisha Olive-McCoy's lower lip puffs up; then her cheeks and jaw twist and pull, distorting her face into an involuntary grimace. Sometimes her tongue will fill up the back of her throat and choke off her breathing. Olive-McCoy, 44, has hereditary angioedema (HAE), a life-threatening disease so rare that many doctors have only read about it. Fortunately, there are cutting-edge drugs to keep the swelling at bay and treat the attacks that break through. (Johnson, 4/25)

Kaiser Health News: Dissecting The Rhetoric Vs. Reality Of Trump's Tough Talk On Drug Prices
President Donald Trump has railed against the high price of prescription drugs and famously bemoaned how pharmaceutical companies are "getting away with murder." Yet, many Americans aren't seeing a change in what they pay out-of-pocket. Trump promised a speech on prescription drug prices, and it's expected anytime.Here's a look at the rhetoric thus far versus the results. (Tribble, 4/27)

And in other pharmaceutical news —

The Hill: Experimental Drugs Bill Runs Aground Despite Trump, Pence Support
Advocates for White House–backed legislation intended to make it easier for sick patients to get access to experimental drugs are frustrated, believing that congressional momentum behind "right to try" has ground to a halt. Despite vocal support from President Trump and Vice President Pence, the House and Senate have made little if any progress on bridging differences with each other over separate bills that have passed each chamber. (Roubein, 4/26)

Stat: FDA Could Re-Examine Safety Of Acadia Pharma Drug
Acadia Pharmaceuticals' (ACAD) share price has flagged since an April story by CNN that highlighted serious and sometimes fatal side effects tied to Nuplazid, its recently approved treatment for symptoms of Parkinson's disease. Now FDA Commissioner Scott Gottlieb has promised to "go back and take another look." And that could mean

bringing Nuplazid in front of another FDA advisory panel, which would allow outside experts to take a second, closer look at the drug's safety profile. (Garde and Feuerstein, 4/26)

Stat: Two FDA Officials To Retire From Drug Review Divisions
Two Food and Drug Administration directors will retire this week, according to the agency. The departures leave three of the FDA's 19 drug review divisions without permanent leaders. Dr. Curtis Rosebraugh, who runs an office that oversees three drug review divisions, will be leaving the FDA. Also retiring is Dr. Donna Griebel, who directs the division that reviews drugs for gastrointestinal disease and some metabolic diseases. Both are retiring effective Saturday; neither returned a request for comment. (Swetlitz, 4/26)

Stat: New York Panel Votes To Lower The Cost Of A Pricey Vertex Drug For Cystic Fibrosis
In the first test of a new law designed to lower drug costs, a New York state panel voted unanimously to seek an additional rebate for a pricey cystic fibrosis drug for the state Medicaid program. The decision comes in response to concerns that the medicine, which is called Orkambi and has a list price of $272,000, may cause the state Medicaid program to exceed a cap on drug spending. In a 10-to-0 vote, the state Department of Health was authorized to negotiate with Vertex Pharmaceuticals (VRTX) for a rebate that would bring the cost down to about $83,200 and match cost effectiveness estimates. (Silverman, 4/26)

WOMEN'S HEALTH

9. Executive Order Cutting Planned Parenthood Out Of Title X Family Planning Grants May Come Next Month

If the executive order is signed, federally qualified health centers would have to take on about 2 million extra patients for contraceptive services, according to the Guttmacher Institute, a women's reproductive health policy think tank. Meanwhile in Texas, more women are getting health and family planning services after a statewide marketing push.

Modern Healthcare: Trump Could Ban Title X Funding For Planned Parenthood
The Trump administration will cut Planned Parenthood out of Title X family planning grants with an executive order expected in early May, according to a White House aide. It's the most drastic move in President Donald Trump's strategy to reshape Title X. The program offers family planning services for about 4 million people, and 1.6 million, or 40%, of these get their Title X-funded care at Planned Parenthood clinics, according to the Guttmacher Institute, a women's reproductive health policy think tank. Trump's 2018 and 2019 budget blueprints called for banning all federal funding to Planned Parenthood. (Luthi, 4/26)

Texas Tribune: Report: Thousands More Texas Women Being Served In Health Programs
Texas served thousands more people in its women's health and family planning programs last year compared to the year before. But it's impossible to say if the number of women accessing such services has returned to the levels they were at before massive budget cuts during the 2011 legislative session. (Evans, 4/26)

Austin American-Statesman: TX Women's Program Makes Gains After Years Of Waning Participation
After the state pursued a multi-million dollar marketing campaign to enroll more women in the program, the number of women served in 2017 increased by 29 percent since last year, from 70,336 to 122,406, according to the new report, which was mandated by the Texas Legislature last year. The number of providers also increased 16 percent between 2015 and 2017 and the number of women who received long-acting reversible contraception, like intrauterine devices, also increased. In 2017, 10,203 women in the Healthy Texas Women Program and 7,675 women in the state's Family Planning Program received a form of the contraception. (Chang, 4/26)

And in other women's health news —

CQ: Abortion Squabble Delays House Panel Debate On State Bill
A planned House Foreign Affairs markup of the State Department policy bill has been indefinitely postponed, with members of both parties blaming Rep. Christopher H. Smith's insistence on debating abortion amendments for the delay. The New Jersey lawmaker is a senior Republican on the panel and has been considered a possible

successor to Chairman Ed Royce, R-Calif., who is retiring at the end of this Congress. But the markup squabble could ultimately hurt his leadership prospects. (Oswald, 4/26)

Kansas City Star: Planned Parenthood Disputes Missouri Medication Abortion Law
Two Planned Parenthood groups — Comprehensive Health of Planned Parenthood Great Plains and Reproductive Health Services of Planned Parenthood of the St. Louis Region — are pushing for a preliminary injunction to block the law, which they say is causing "irreparable harm" to the clinics and their patients and imposing an undue burden on women's right to choose abortion. They're squaring off in federal court against the Missouri Attorney General's Office, which is representing the state. (homas, 4/26)

OPIOID CRISIS

10. The Research Is Clear: Needle Exchanges Reduce Deaths And Don't Increase Drug Use. So Why Are Many Of Them Closing?

Charleston, W.Va. is at the very heart of the opioid crisis, yet the city just shut down its needle exchange, which has been shown to save money and cut the spread of disease while not increasing drug use. Experts look at why such programs, which seem like no-brainers to many, struggle to gain public acceptance.

The New York Times: Why A City At The Center Of The Opioid Crisis Gave Up A Tool To Fight It
To its critics here, the needle exchange was an unregulated, mismanaged nightmare — a "mini-mall for junkies and drug dealers" in the words of Danny Jones, the city's mayor — drawing crime into the city and flooding the streets with syringes. To its supporters, it was a crucial response to an escalating crisis, and the last bulwark standing between the region and a potential outbreak of hepatitis and H.I.V. When Charleston closed the program last month after a little more than two years of operation, it was the latest casualty of a conflict playing out in a growing number of American communities. At least seven other such exchanges have closed in the past two years, even as dozens of others have opened. (Katz, 4/27)

In other news, efforts to curb the opioid crisis have made it difficult for patients to get help, Minnesota finalize prescription guidelines, and a look at the country's other drug problem —

The Wall Street Journal: Opioid Crackdown Has Patients Struggling To Get Their Meds
The war on opioids is making it tough for Evelyn Lopez to get narcotic pain medication. A doctor recently stopped prescribing an opioid she had taken for years, saying it wasn't worth possible federal scrutiny. Ms. Lopez, a 53-year-old cancer survivor, also must travel 45 minutes to pick up another opioid prescription because her doctor isn't allowed to call a pharmacy for a refill. "I have to jump through more and more hurdles," said Ms. Lopez, of Hazlet, N.J., who has chronic pain from treatment for her non-Hodgkin lymphoma, which is in remission. "For people like me who depend on this medication, what they're doing is a huge injustice." (Armour, 4/26)

Minnesota Public Radio: Minn. Finalizes Guidelines For Opioid Prescriptions
After three years of work, the state of Minnesota has finalized guidelines for how doctors should prescribe opioid painkillers that include starting certain patients on the lowest effective dose. (Collins, 4/27)

NPR: Valium, Xanax And Ativan: More Popular, Still Risky
Drew was in his early 30s. His medical history included alcohol abuse, but he had been sober for several months when he became my patient. His previous doctor had given him a prescription for Ativan, or lorazepam, which is frequently used to allay tremors and seizures from alcohol withdrawal. My first inclination was to wean him off the medication by lowering the dose and telling him to take it less frequently. But inertia is strong in medical care, and Drew prevailed upon me to continue providing lorazepam at his regular dose for another month while he solidified his situation with a new job. (Schumann, 4/26)

PUBLIC HEALTH AND EDUCATION

11. Genealogy Site Helps Police Nab Alleged Golden State Killer, Raising Concerns Among Privacy Experts

Investigators took DNA collected years ago from one of the crime scenes and submitted it in some form to one or more commercial genealogy websites that have

built up a vast database of consumer genetic information. The results led law enforcement to the suspected killer's distant relatives.

Stat: What Does The Golden State Killer Arrest Mean For Genetic Privacy?
The identity of one of California's most notorious serial killers had been a mystery for decades — until this week, when law enforcement arrested a suspect. Investigators revealed on Thursday that they made the breakthrough using a remarkable tool: a commercial genealogy website. The unusual manner in which the Golden State Killer case was cracked has sparked wonderment — as well as privacy concerns about how law enforcement can and does use the genetic information that consumers give up to genetic testing companies. That's because companies generally say on their websites that a customer's genetic information can be shared with law enforcement if demanded with a warrant. (Robbins, 4/26)

Sacramento Bee: East Area Rapist: Questions About Use Of DNA From Genealogy Sites
Millions of Americans are doing it – packing up samples of their saliva and mailing it off to an online genealogy company to analyze their DNA and help trace their family tree. Without knowing it, they may be helping law enforcement crack difficult cases. (Kasler and Chabria, 4/26)

The Associated Press: A Look At DNA Testing That ID'd A Suspected Serial Killer
Joseph James DeAngelo, who authorities suspect is the so-called Golden State Killer responsible for at least a dozen murders and 50 rapes in the 1970s and 80s, was arrested more than three decades after the last killing with the help of information from an online genealogical site. Investigators haven't disclosed many key elements about how and why they took this very unusual step to find a suspect. Here's a look at the case and some of the questions surrounding it. (Balsamo, 4/27)

The New York Times: Do Serial Killers Just Stop? Yes, Sometimes
The Golden State Killer's barrage of rapes and murders began in a gold mining area east of Sacramento in 1976. By 1986, it seemed to have stopped.Why? With the arrest Tuesday of Joseph James DeAngelo, 72, who has been charged so far with eight counts of murder, more than 30 years had passed since the last episode in the series.

That long period of quiescence seems to fly in the face of the popular belief that serial rapists and killers are incapable of stopping. (Hoffman, 4/26)

12. Autism Rates Have Increased, But Experts Attribute It To Better Diagnosis Practices For Minority Children

About 1 in 59 U.S. children were identified as having autism in 2014. The report also found that white children are diagnosed with autism more often than black or Hispanic children, but the gap has closed dramatically.

The Associated Press: More Kids Have Autism, Better Diagnosis May Be The Reason
The government estimates that autism is becoming more common, but it's only a small increase and some experts think it can be largely explained by better diagnosing of minority children. About 1 in 59 U.S. children were identified as having autism in 2014, according to a Thursday report from the Centers for Disease Control and Prevention that focused on 8-year-old children. That's up from 1 in 68 children in both 2010 and 2012. (Stobbe, 4/26)

Los Angeles Times: Here's Why The Apparent Increase In Autism Spectrum Disorders May Be Good For U.S. Children
Normally, health officials would prefer to see less of a disease, not more of it. But in this case, the higher number is probably a sign that more children of color who are on the autism spectrum are being recognized as such and getting services to help them, according to a report published Thursday by the Centers for Disease Control and Prevention. The data come from the CDC's Autism and Developmental Disabilities Monitoring Network. ADDM researchers pore over medical reports from pediatric clinics, neurologists, child psychologists, speech pathologists and physical therapists, as well as records of special education services provided through public schools. (Kaplan, 4/26)

Bloomberg: Autism Disorder Increases In U.S. Children, CDC Study Finds
The study, based on 2014 research, again identifies New Jersey with the highest incidence. One in 34 children in that state, or 3 percent, fall on what's called the autism spectrum, which encompasses a range of social, behavioral and learning disorders ranging from the barely noticeable to the profoundly debilitating. (Young, /26)

13. New CDC Chief On Board With Researching Gun Violence, Schumer Says

Senate Minority Leader Chuck Schumer said that he hopes the CDC "will use some of their newly increased resources from the omnibus spending package to get this done." In other public health news: the E. coli outbreak, cancer, amputations, our ancestors' brains, and more.

The Hill: Schumer: CDC Chief 'Agreed' Agency Can Study Gun Violence
Senate Minority Leader Chuck Schumer on Thursday said President Trump's new director of the Centers for Disease Control and Prevention (CDC) believes there isn't a prohibition on his agency researching gun violence. Robert Redfield "agreed there is no longer a prohibition on the CDC conducting research on the gun violence epidemic," Schumer said after a meeting with Redfield. "That is a good first step but we have a lot of work to do to ensure the CDC initiates this extremely important research in the near future." (Weixel, 4/26)

The New York Times: E. Coli Flare-Up Is Largest Multistate Outbreak Since 2006
A recent spate of infections linked to romaine lettuce is now the largest multistate food-borne E. coli outbreak since 2006, according to data from the Centers for Disease Control and Prevention. At least 84 people were infected in 19 states between mid-March and mid-April, the C.D.C. announced Wednesday, adding more than two dozen cases to its previous count. Because of the time it takes for an illness to reach the agency's attention, illnesses contracted after April 5 may not yet have been reported, the agency said. (Chokshi, 4/26)

Los Angeles Times: For Firefighters Who Worked In World Trade Center Rubble, The Future Includes A Heightened Risk Of Cancer
It's been nearly 16 years since cleanup work officially ended at New York City's ground zero, but the health effects for rescue and recovery workers are still making themselves known. Two studies published Thursday in the journal JAMA Oncology suggest that the firefighters who came to lower Manhattan after the Sept. 11, 2001, attacks on the World Trade Center face a heightened risk of cancer — and will continue to do so for years to come. (Kaplan, 4/26)

The Washington Post: Why Surgeons Amputated A 7-Year-Old's Leg And Reattached It The Wrong Way
Not long before her seventh birthday, Amelia Eldred, a small dancer with big dreams of performing on stage, received a devastating diagnosis. Doctors discovered a 10-centimeter tumor in the femur in her left leg — and it had broken the bone, according to Birmingham Live. When the tumor did not respond to chemotherapy, doctors told her parents that the limb would need to be amputated, but they had a solution to help the active child maintain her mobility, according to the British news site. (Bever, 4/26)

Los Angeles Times: The Shape, Not Size, Of Our Ancestors' Brains May Have Helped Them Outlast Neanderthals
For more than 200,000 years, Neanderthals successfully occupied the cold, dark forests and shores of Europe. Then early humans came along. Archaeological evidence suggests that human migrants from Africa arrived on the European continent around 40,000 years ago. About that same time, the Neanderthals all died off. (Netburn, 4/27)

Stat: He Was A Tuskegee Study Architect. Should A College Expunge His Name?
Dr. Thomas Parran Jr., whose name graces the main building of the University of Pittsburgh Graduate School of Public Health, has also been called an architect of the syphilis experiments on black men and women in Tuskegee, Ala. While he was surgeon general, he was also aware that U.S. public health researchers were intentionally infecting with syphilis Guatemalan people who were mentally ill or in prison, in the name of research. Now, under pressure from students who say Parran's role in these experiments shows his disregard for human lives, the university is grappling with whether to strip his name from the building, and by default, the school he helped found after decades of public service. (Satyanarayana, 4/27)

WBUR: Why You Keep Waking Up At Night? It May Be Your 'Neuronal Noise'
In a new paper in the journal Science Advances, researchers from Boston University and Israel offer an explanation for these "short arousals." They blame "neuronal noise" — random fluctuations in your neurons' voltage that sometimes rise to the level of waking you up. (Goldberg, 4/26)

The New York Times: Caffeine During Pregnancy Tied To Overweight Offspring
Consuming caffeine during pregnancy may increase the risk for obesity in childhood,

researchers report. A Norwegian study, in BMJ Open, involved 50,943 mother-infant pairs. The mothers reported their caffeine intake at 22 weeks of pregnancy, and the researchers followed their children over the next eight years. After adjusting for other variables, the scientists found that compared with the children of women who consumed less than 50 milligrams of caffeine a day, those whose mothers had 50 to 199 milligrams were only slightly more likely to be overweight at ages 3 through 8 years. (A cup of brewed coffee contains about 100 to 150 milligrams of caffeine.) (Bakalar, 4/26)

MARKETPLACE

14. ProMedica Scoops Up Nursing Home Provider: 'When You Look At The Trends ... You Fight It Or Go All In'

The move is just the latest in a flurry of acquisitions and mergers that are taking place in the ever evolving health care landscape.

Modern Healthcare: ProMedica To Acquire HCR ManorCare
Not-for-profit health system ProMedica is taking a giant step outside of the traditional hospital space with its plan to acquire bankrupt nursing home provider HCR ManorCare for about $1.4 billion through a complex proposed deal. Running parallel to the deal is real estate investment trust Welltower's agreement to buy HCR's landlord, fellow REIT Quality Care Properties, in a cash deal for $20.75 per share, or roughly $2 billion. Welltower and ProMedica also formed a joint venture for QCP's real estate in which Welltower will own 80% and ProMedica will own 20%. (Bannow, 4/26)

In other health industry news —

Dallas Morning News: Tenet Spends $630 Million To Boost Stake In Addison-Based Outpatient Surgery Company
Tenet Healthcare has spent $630 million to increase its stake in an Addison-based company that operates a 28-state network of outpatient surgery, imaging and urgent care facilities. Tenet, a national hospital operator based in Dallas, now owns 95 percent of United Surgical Partners International, an announcement Thursday said. Baylor University Medical Center owns the other five percent. (Rice, 4/26)

15. State Highlights: Black Lung Resurgence Is Another Broken Promise In West Virginia; Montana Couple Spends Savings On 'Miracle' Diabetes Cure

Media outlets report on news from West Virginia, Montana, Colorado, Georgia, Florida, Connecticut, New Hampshire, Massachusetts, Wisconsin, Ohio, Missouri, Tennessee, Minnesota and California.

ProPublica: Covering West Virginia's Long History Of Broken Promises
Congress promised in 1969 to eliminate black lung disease. But thousands of miners — including Jimmy Woolum — continued to die from it. Today, though the industry knows how to prevent black lung, there's a resurgence of the disease among miners in Central Appalachia. (Ward Jr., 4/27)

inewsource: Montana Couple Sinks Life Savings Into 'Miracle' Diabetes Treatment
Ron Briggs used to call himself a "good cash cow for the medical industry." That's because every few weeks, an ambulance would rush across the rugged, cowboy town of Dillon, Montana, sirens blaring, to revive him from a diabetic coma. The nation has a limited supply of healthcare dollars to spend on drugs and services, which is why the government and health plans require scientific evidence of patient benefit. This is especially important for the 30.3 million people in the U.S. with diabetes, whose medical costs in 2012 totaled $245 billion. He and his wife, Julie, a strong and mothering woman where Ron is concerned, gets choked up when they talk about those days, some four years ago. Those days before they found their "miracle" for treating his disease — the same miracle that would be at the heart of a criminal indictment, embroil them in a lawsuit and lead to their financial ruin. (Clark, 4/26)

Denver Post: Colorado Bill Relies On Transparency To Lower Health Care Prices, Critics Say It Might Not Work
But, in health care, knowing the sticker price doesn't always help in understanding what you'll actually pay. All sorts of factors can intervene — such as where you live and how far you are willing to drive for care or whether you have insurance and whether your insurer contracts for special prices at only certain hospitals. And the flat price doesn't

tell you anything about the track record of a hospital in performing the procedure. (Ingold, 4/26)

Atlanta Journal-Constitution: He Was Caught On Video, But Georgia Doctor Kept His Medical License
[Daniel] Tesfaye's case, one of the hundreds examined by The Atlanta Journal-Constitution as part of its latest investigation of doctors and sex abuse, shows how the secrecy and influence that permeate the system can provide cover even for a physician graphically caught in the act. A decade before he treated Miller, Tesfaye had been admonished by the medical board in North Carolina, where he was then practicing, for inappropriate behavior with female patients. (Robbins, 4/26)

Miami Herald: Beset By Rapes, Rats, Scalding, Florida Home For Disabled Could Lose License
Since at least 2013, when a severely disabled Broward County girl died in slow agony from an untreated illness, the Carlton Palms Educational Center has been under an administrative microscope as state regulators sought vainly to shut it down. ...Many of the incidents are documented in a disturbing administrative complaint that seeks to revoke Carlton Palms' license, citing a years-long culture of abuse and neglect that was "either fostered, condoned or negligently overlooked" by administrators. (Marbin Miller and Madan, 4/26)

The CT Mirror: Workers Who Care For Disabled Vote To Strike May 7
In March, the worker's union, SEIU 1199 New England, held a rally at the State Capitol to announce that some 2,500 workers from nine organizations intended to strike on April 18, seeking increased state funding and higher wages. These employees work for private agencies in group homes and day programs that receive state funding, with the majority of that coming from the state Department of Developmental Services. (Rigg, 4/26)

New Hampshire Public Radio: N.H House Approves Tax Breaks For Human Organ Generation Businesses
Companies in the business of growing human organs would be exempt from paying two New Hampshire taxes for the next ten years under a bill passed on Thursday by the New Hampshire House. Supporters of the bill argue that tax breaks will help kick start a

nascent industry and ensure that New Hampshire becomes the 'Silicon Valley of regenerative medicine.' (Bookman, 4/27)

Boston Globe: Mass. General To Partner With Maine Health System
Mass. General officials said Thursday that they will form a clinical affiliation with Eastern Maine Healthcare Systems, or EMHS. The organization operates nine hospitals and is based in Brewer, Maine, nearly 250 miles from the Mass. General campus in Boston. (Dayal McCluskey, 4/26)

Milwaukee Journal Sentinel: Kids In Crisis: Wisconsin Youth Mental Health Efforts Seek Answers
In hundreds of mailboxes each year, letters from state health authorities arrive at the homes of children with serious emotional disorders like hyperactivity and persistent depression. ... In every survey from 2006 to 2016, fewer than half of responding parents said their children saw positive results from services, placing Wisconsin in recent years near the bottom of the Midwest and nation in surveys that states complete for federal mental health grants. (Kyle and Linnane, 4/26)

Cincinnati Enquirer: Hepatitis A: High-Risk Ohioans Encouraged To Get Vaccination
Cases of hepatitis A have skyrocketed in Ohio and the Department of Health is encouraging at-risk individuals to get vaccinated. There have been 47 cases of hepatitis A so far in 2018, compared to five cases during the same timeframe in 2017, the Department of Health said in a statement on Thursday. (Brookbank, 4/26)

The Washington Post: Smoke From Wisconsin Refinery Explosion Poses Health Risk
An explosion and asphalt fire at a Wisconsin oil refinery on Thursday sent huge plumes of smoke into the air that pollution experts said almost certainly contained large amounts of toxins, posing a serious health risk to those living downwind. Asphalt is a petroleum product that when burned emits chemicals in gaseous form and small particles that can linger long after the smoke dissipates, said Wilma Subra, a chemist with the Louisiana Environmental Action Network who has examined past refinery accidents. (Brown, 4/27)

Kansas City Star: Measles Exposure Possible At St. Joseph Medical Center
St. Joseph Medical Center is among seven new sites where people may have been exposed to measles during an outbreak that has sickened 10 Missourians so far. ...The

patient with measles went through the main lobby of the medical center and used elevators to get to the pediatric practice, but Beeler said the inpatient tower has a separate entrance and elevators. (Marso, 4/26)

Nashville Tennessean: Walk-In Clinic Opening In Nolensville
A walk-in clinic is opening in Nolensville next week. Vanderbilt Health and Williamson Medical Center are opening their fifth walk-in clinic in Williamson County on April 30 at 940 Oldham Drive. Clinicians can treat common illnesses including coughs, ear and eye infections, flu, colds, sinus infections and stomach viruses. (Sauber, 4/26)

The Star Tribune: HealthEast Merger Weighs On Fairview Financial Results
A big merger with HealthEast, the St. Paul-based network of hospitals and clinics, weighed on the financial performance last year for Fairview Health Services, contributing to a 25 percent decline in operating income. The effect was not a surprise given the relative profitability of the two health systems and should give way to better financial performance in the future, said Dan Fromm, the Fairview chief financial officer, in an interview Thursday. (Snowbeck, 4/26)

New Hampshire Public Radio: Marsy's Law Constitutional Amendment Dies In N.H. House
A proposed constitutional amendment known as Marsy's Law failed in the New Hampshire House of Representatives on Thursday, despite a well-organized and well-financed effort by supporters. The amendment would have created a list of constitutional rights designed to give crime victims a greater say in the court system. (Moon, 4/26)

Boston Globe: Worker Deaths Continue To Rise In Mass.
Wright Davis is among a growing legion of independent contractors and temp workers with few if any employment protections, and one of at least two such workers killed on the job in Massachusetts last year, according to a report released Thursday by the Massachusetts Coalition for Occupational Safety and Health, known as MassCOSH. Overall, 74 people in the state lost their lives because of work-related accidents and illnesses in 2017 — an 11-year high, reflecting a nationwide rise in worker deaths — and contractor and temp fatalities are expected to grow as companies rely more heavily on them. (Johnston, 4/26)

California Healthline: Millions Eligible For Food Stamps In California Don't Reap The Benefit
Millions of low-income Californians eligible for food stamps are not receiving the benefit, earning the state one of the lowest rankings in the nation for its participation in the program. Just three states — all much more conservative than the Golden State — have lower rates of participation, according to the latest available federal data. The poor performance stands in sharp contrast to California's leadership on enrollment in Medi-Cal, the state's version of Medicaid, which also serves people living in low-income households. (Gorman and Rowan, 4/26)

HEALTH POLICY RESEARCH

16. Research Roundup: The Opioid Crisis; Short-Term Plans; Systematic Cross-Checking

Each week, KHN compiles a selection of recently released health policy studies and briefs.

Urban Institute: Critical Value: Treating The Opioid Crisis
The opioid epidemic is the deadliest drug crisis in American history, and it demands a multifaceted response. This week, we focus on one crucial facet: medical treatments for opioid addiction, including buprenorphine and methadone. These drugs are proven to help people in recovery—so why aren't they reaching everyone who needs them? Host Justin Milner talks to health policy expert Lisa Clemans-Cope about the evidence behind these treatments, the barriers to access, and the evolution of the opioid crisis. (4/11)

The Henry J. Kaiser Family Foundation: Analysis: Most Short-Term Health Plans Don't Cover Drug Treatment Or Prescription Drugs, And None Cover Maternity Care
A new Kaiser Family Foundation analysis of short-term, limited duration health plans for sale through two major national online brokers finds big gaps in the benefits they offer. Through an executive order and proposed new regulations, the Trump Administration is seeking to encourage broader use of short-term, limited duration health plans as a cheaper alternative to individual market plans that comply with the Affordable Care Act's requirements. Repeal of the individual mandate penalty – which currently applies

to people buying short-term plans – is also expected to boost enrollment starting next year. (4/23)

JAMA Internal Medicine: Effect Of Systematic Physician Cross-Checking On Reducing Adverse Events In The Emergency Department: The CHARMED Cluster Randomized Trial
In this cluster randomized trial that included 1680 patients, the implementation of systematic cross-checking between physicians resulted in a significant relative risk reduction for adverse events. The rate of adverse events was 10.7% in the control group vs 6.4% in the cross-checking group. (Freund, Goulet and Leblanc, 4/23)

New England Journal of Medicine: Birth Outcomes For Pregnant Women With HIV Using Tenofovir–Emtricitabine
In a previous trial of antiretroviral therapy (ART) involving pregnant women with human immunodeficiency virus (HIV) infection, those randomly assigned to receive tenofovir, emtricitabine, and ritonavir-boosted lopinavir (TDF–FTC–LPV/r) had infants at greater risk for very premature birth and death within 14 days after delivery than those assigned to receive zidovudine, lamivudine, and ritonavir-boosted lopinavir (ZDV–3TC–LPV/r). (Rough et al, 4/26)

The Henry J. Kaiser Family Foundation: Health Care In Puerto Rico And The U.S. Virgin Islands: A Six-Month Check-Up After The Storms
Puerto Rico and the U.S. Virgin Islands (USVI) suffered significant damage to their infrastructure and health care systems from Hurricanes Irma and Maria in September 2017. Drawing on interviews with residents and key stakeholders as well as public reports, this brief provides an overview of the status of the recovery efforts six months after the storms, with a focus on the health care systems. (Artiga, Hall, Rudowitz and Lyons, 4/24)

EDITORIALS AND OPINIONS

17. Viewpoints: Here's Hoping Trump Finally Shows Care For Veterans' Health; GOP's War On The Poor Expands

Editorial writers look at these and other health topics.

The Washington Post: Our Veterans Require Great Care. Trump Hasn't Shown Any.
"We will take care of our great veterans like they have never been taken care of before." That promise from Donald Trump after he won his party's presidential nomination is worth revisiting in light of the debacle (completely of President Trump's own making) that surrounded the nomination, and subsequent withdrawal from consideration, of White House physician Ronny L. Jackson as veterans affairs secretary. Facing — for the third time in his presidency — the question of who should lead this critical agency, Mr. Trump needs to recall what is paramount: the welfare of the men and women who have selflessly served their country. (4/26)

The Wall Street Journal: The Character Assassination Of Ronny Jackson
Attacking the character of presidential nominees is among Washington's favorite sports. But by creating and distributing a compilation of anonymous smears against White House physician Dr. Ronny Jackson, Montana Democrat Sen. Jon Tester appears to be setting a new Beltway record for unsportsmanlike conduct. Today Dr. Jackson, a rear admiral in the U.S. Navy, withdrew from consideration to be Secretary of Veterans Affairs. This followed Mr. Tester's unique contribution to public discourse and civility—a collection of unsourced and unverified claims that the man lauded and trusted by Presidents of both parties is in fact a reckless, dishonest, mean-spirited drunk. (James Freeman, 4/26)

The New York Times: Trump's War On The Poor
America hasn't always, or even usually, been governed by the best and the brightest; over the years, presidents have employed plenty of knaves and fools. ... This year, however, the G.O.P.'s main priority seems to be making war on the poor. That war is being fought on multiple fronts. The move to slash housing subsidies follows moves to sharply increase work requirements for those seeking food stamps. Meanwhile, the administration has been granting Republican-controlled states waivers allowing them to impose onerous new work requirements for recipients of Medicaid — requirements whose main effect would probably be not more work, but simply fewer people getting essential health care. (Paul Krugman, 4/26)

The Detroit News: Reform Welfare For Able-Bodied
Michigan is experiencing the longest sustained period of job growth since World War II, but you wouldn't know it from the number of work-capable people on food assistance. Despite significantly lower unemployment, more residents receive food assistance

today than in 2008. Back then, the unemployment rate was 8.4 percent and 12.9 percent of the state received Food Assistance Program (FAP) payments. Now, the unemployment rate has plunged to 4.7 percent, yet 13.4 percent of the population still claims FAP benefits. Part of this is due to a loophole in federal law that allows Michigan to exempt large numbers of able-bodied adults from welfare work requirements, even if they have no dependents. Amid a roaring recovery, the state is enabling adults fully capable of working to instead sit on the sidelines and out of the labor force. (Mimi Teixeira, 4/26)

USA Today: Paying For Health Care In Retirement Is Expensive. Here's How To Plan
Retirement and health care are intricately linked, though Americans often don't think of them in the same context. And just as many people are behind in accumulating the money needed to pay for a comfortable retirement, plenty are falling short in estimating and preparing for out-of-pocket health-related expenses. (Russ Wiles, 4/26)

The Detroit News: Vaccines Can Save Childrens' Lives
As parents, we do everything in our power to protect our children. When we consider all the ways we keep our children safe, immunization may not always be top of mind. In reality, it's one of the most important things you can do to protect your child, from the moment they are born through their teens and into adulthood. In fact, for kids born between 1994 and 2016, vaccines will prevent an estimated 855,000 deaths in their lifetimes. (Veronica McNally, 4/25)

WBUR: Defending Hospitals Against Life-Threatening Cyberattacks
Protecting hospitals' computer networks is crucial to preserving patient privacy -- and even life itself. Yet recent research shows that the health care industry lags behind other industries in securing its data. (Mohammed Jalali, 4/26)

The Washington Post: Robert Redford: The Biggest Scott Pruitt Scandal Is The One Right In Front Of Us
(Scott) Pruitt has become a one-man public-health risk to the air we breathe, the water we drink and the food we eat. From day one, he has worked to gut the EPA and hamstring its ability to protect the environment and public health. He works on behalf of the fossil-fuel industry and other industrial polluters, not the American people. That's

the greatest scandal — and the reason, first and foremost, he's got to go. (Robert Redford, 4/26)

Des Moines Register: Before Environment Was A Partisan Issue, Ding Darling, Ray Led The Way
"As land goes, so goes man," says a cartoon by the late Des Moines Register cartoonist Ding Darling. About a century later, his warnings about environmental degradation feel more urgent than ever. Our soil is eroding because of a lack of land stewardship and a monoculture of corn instead of healthy biodiversity. Our waterways are tainted by runoff from phosphorus and nitrogen from livestock confinements. (Rekha Basu, 4/26)

Seattle Times: Lawmakers, Stop Shortchanging Anti-Smoking Programs
Slapping a $3.03 tax on each pack is part of the state's multipronged approach to dissuade people from smoking. Yet increasingly, the state is failing to reinvest its substantial tobacco-tax windfall into tried-and-true prevention programs that further reduce smoking rates and help people trying to quit. (4/25)

San Diego Union-Times: Opioids And County Jails: A Lesson For U.S.
The failure of Congress and the Obama and Trump administrations to aggressively address the opioid epidemic is a bipartisan indictment of our political establishment. That's not just because opioid overdoses have killed more than 250,000 people over the past decade. It's because of the growing reasons to think other drugs could have been used much more safely for pain relief in place of habit-forming drugs like OxyContin and Percocet that have created so many American addicts. ... Now there's more evidence from our own backyard that opioids have been grossly overprescribed. A recent report in The San Diego Union-Tribune detailed how county jail officials had cut back opioid prescriptions from nearly 1,000 in early 2013 to 23 last month after adopting best-practices standards that focused on the risk prisoners face from opioids and the effectiveness of far less potent medicines like acetaminophen and ibuprofen. This was done, reassuringly, with relatively few complications. (4/26)

Richmond Times-Dispatch: When It Comes To The Opioid Crisis, Medicaid Is Part Of The Solution
Opioid use across the country is rampant, and the impact on our communities is

terrifying. Lack of health insurance and ongoing stigma about mental health and substance use keep many from seeking treatment. (Eric Blevins, 4/27)

Los Angeles Times: Conversion Therapy For Gays Is Awful, But So Is California's Bill To Ban It

That a tiny market for conversion therapy to "cure" homosexuality still exists today is deeply sad, even infuriating. But here's the question: If a competent adult knows the most devastating critiques, and wants to pay for it anyway, should California law thwart him or her? The Assembly thinks so. Assembly Bill 2943, which State Rep. Evan Low shepherded through passage last week, declares that "the potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient." (4/27)

Boston Globe: Beginning To Talk About The End

It's the conversation no one wants to have. But on a chilly spring afternoon, 18 people have come to a small office building to start to have it. They are older residents of Cambridge and surrounding towns, and they're meeting to talk about death — "but not so much about death," says one of the presenters, paraphrasing the writer and physician Atul Gawande, "as about living a good life right up until the end." The meeting is held at Cambridge Neighbors, a nonprofit group that helps people stay in their homes, and stay connected to their communities, as they get older, with programs ranging from wellness and exercise classes, to book groups, to assistance with transportation and grocery shopping. (Joan Wickersham, 4/27)

Alexander, Steven

From: Gongwer News Service <gongwerreports@gongwer-oh.com>
Sent: Wednesday, April 25, 2018 6:13 PM
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OHIO REPORT
WEDNESDAY, APRIL 25

Senate Leader Points To Variety Of Proposals After Kasich Urges Gun Safety Bill Vote

PUCO Approves Modified AEP Rate Settlement

House GOP To Vote May 15 On Next Speaker

Coal Group, Farm Bureau Urge Panel To Maintain Industry Tax Exemptions

Supreme Court Keeps In Place Rulings On Transfer Agreement, Autopsies

High Court Clarifies Appellate Review Of Arbitration Appeals

Cordray Campaign Pledges To Protect, Expand Veterans Benefits

Obhof OK With Legislative Look At E-School Enrollment Rules; OSU Joins Anti-Poverty Effort; Portman Bill Targets Tech Teacher Training; Auditor Issues Bus Study…

Space Embarks On Tour To Highlight Corruption; Cordray Launches New Ad; Yuko Gets SEIU Backing…

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Volume #87, Report #80 -- Wednesday, April 25, 2018

Senate Leader Points To Variety Of Proposals After Kasich Urges Gun Safety Bill Vote

Gov. John Kasich wants to see a set of gun safety proposals he is supporting come up for a vote, but one legislative leader said his chamber is working through several firearm-related issues.

The governor said Tuesday he hoped to see a vote on a proposal (HB 585 & SB 288) to make several changes to the state's gun laws. (See Gongwer Ohio Report, April 5, 2018)

Gov. Kasich pointed to the deadly shooting over the weekend at a Tennessee Waffle House restaurant, saying the state needs a "red flag" law to seize guns from people determined to be dangerous. That someone was able to stop the shooter while he reloaded also shows the need for limiting the capacity of magazines, the governor said.

The governor's proposals, particularly the "red flag" language creating extreme risk protection orders, have met pushback from some Republican legislators. (See Gongwer Ohio Report, April 10, 2018)

Gov. Kasich said he still expects the proposal to become law.

"We're going to get this package through," he said. "This is going to happen. It's not going to be easy to duck and run away and put your head in the sand. I will not let that happen. Maybe they can stop it, but it isn't going to be without a lot of people feeling a lot, a lot of pressure."

The governor said the gun safety proposal would likely pass if brought up for a vote.

"Bring it up and have a vote on it," he said. "We'll see where the votes are. Let's see where the majority of the caucus is. I guarantee you, you put this gun safety on the Senate floor, it passes. We need a vote."

Senate President Larry Obhof (R-Medina) said Wednesday he doesn't expect that exact proposal to come to the floor of his chamber, but that members are looking at several different items that could eventually pass.

"We have a very open process, we will look at a number of different changes related to firearms, some of which are in line with what the governor is looking at, some of which are longstanding problems that our caucus has felt we had a need to fix," he said.

The Senate leader pointed to legislation ranging from one sponsored by two Republicans to shift the burden of proof in self-defense cases, among other changes (SB 180), to proposals by Democrats to ban bump stocks (SB 219) and to create extreme risk protection orders (SB 278).

"Whether anything passes or whether a lot of it passes, we'll decide as a caucus," Sen. Obhof said.

The risk protection order measure, sponsored by Sen. Joe Schiavoni (D-Boardman), is one where Sen. Obhof said he's spoken with the sponsor and with the National Rifle Association in an effort to work out differences.

"Everything's on the table," he said.

PUCO Approves Modified AEP Rate Settlement

The Public Utilities Commission of Ohio's approval Wednesday of AEP Ohio's new rate plan sets the stage for what Chairman Asim Haque believes could be the state's longest period of rate stability in the last decade.

Mr. Haque made that assessment moments after the commission voted 4-0 to modify and approve a wide-ranging rate settlement agreement filed last year by AEP and 19 interested party groups. Commissioner Daniel Conway recused himself.

In addition to establishing rates until May 2024, the Electric Security Plan includes a $21.1 million "Smart City Rider" to fund electric vehicle charging station development and microgrid investment.

If the commission later this year approves Duke Energy's own proposed settlement rate plan, rates would be stabilized for all four of Ohio's major electric utilities until the mid-2020s, Mr. Haque said.

"This decision represents stability for AEP customers," Mr. Haque said. "ESPs are big cases. They are time intensive and they are very litigious. To have stability in the AEP footprint...is a very good thing for AEP's current customers and for job creation in AEP's service territory."

The commission's order, which may still be appealed by opponents, has been years in the making.

AEP in 2016 filed its initial proposal but critics said that plan could pave the way for a 120% increase - from $8.40 to $18.40 a month - for affected customers. (See Gongwer Ohio Report, May 16, 2016)

The company filed a settlement agreement last year with 19 parties including the Ohio Manufacturers' Association, the Ohio Environmental Council, Industrial Energy Users-Ohio, the Natural Resources Defense Council to address those concerns. AEP has said the stipulation would lead to a less than 50-cent increase in average monthly bills. (See Gongwer Ohio Report, August 28, 2017)

Julie Sloat, AEP Ohio president and chief operating officer, said in a statement the plan responds to consumer requests.

"Our customers want reliability and access to advanced technologies, such as EV charging stations, microgrids and renewable energy resources," she said.

"Our plan allows us to bring these services, which also will support economic development in Ohio, to customers across the state. The ESP enables us to continue our investments in the electric grid to provide reliable power and help advance the new technologies and cleaner energy that our customers want."

Dan Sawmiller, the NRDC's Ohio energy policy director, said one surprising modification made by the commission in its order is the removal of a provision that would have enabled AEP to push back that requested 120% increase until 2020.

Other wins from supporters' point of view is a $10 million rebate program for electrical vehicle charging stations, $10.5 million for microgrid projects, and regulatory tweaks clearing the way for 900 megawatts of clean energy in Appalachia, Mr. Sawmiller said.

"AEP's now going to be positioned to respond to the expectations of Ohio customers that have been pushing AEP to invest in more clean energy options for years," Mr. Sawmiller said. "On top of that there are some pilot programs in the stipulation and the data and the insight we're going to gain...create the groundwork for a lot of forward-looking progress."

The agreement still has its detractors, including the Ohio Consumers' Counsel, which has argued the deal lacks specifics on customer costs and that the "Smart City Rider" should have been tackled

through a separate rate case. The OCC last month petitioned the PUCO to reopen the case to enable further debate. (See Gongwer Ohio Report, January 2, 2018)

"With the PUCO's approval of AEP's electric security plan today, the trend of charging Ohioans to subsidize outdated and non-competitive power plants continues," OCC spokeswoman Molly McGuire said. "And AEP's plan will also leave consumers paying subsidies for electric vehicle charging, microgrids, large customers (interruptible rates), automakers (bill credits), and possibly renewable energy."

The OCC has continued to press lawmakers to pass a bill (HB 247) banning Electric Security Plans, which it says deprive consumers of the benefits of competitive markets.

But in its order the PUCO determined that the ESP is "more favorable in the aggregate" than a market rate offer, which is the statutory guideline by which the commission evaluates ESPs.

"The ESP proposed in the stipulation affords customers in AEP Ohio's service territory numerous benefits and advances many of the state policy objectives enumerated in (Ohio Revised Code)," the PUCO's order reads.

Commissioner Lawrence Friedeman issued a concurring opinion elaborating on the aforementioned statutory provision - O.R.C. 4928.02 (C) - which establishes state policy as promoting customer choice, encouraging innovation and facilitating the development of the competitive retail electric market through flexible regulatory treatment.

Mr. Friedeman opined that market distortions resulting from cost imbalances might undermine that code section and that those distortions may "erect market barriers which have the tendency not to promote retail competition but rather to have an anti-competitive impact or in an extreme eventuality to re-monopolize the retail market inconsistent with enunciated state policy."

House GOP To Vote May 15 On Next Speaker

House Republicans will vote next month to choose the next speaker, and it is likely that the results of primary elections will influence who gets the gavel.

The majority caucus will vote at noon Tuesday, May 15, to choose its next leader, Speaker Pro Tem Rep. Kirk Schuring (R-Canton) said in a memo to members.

The special caucus will only consider votes for a new speaker to fill out the remainder of the year, not any other leadership positions, Rep. Schuring said.

The new speaker will replace Cliff Rosenberger, who resigned earlier this month amid an investigation by the FBI. (See Gongwer Ohio Report, April 12, 2018)

The speaker's race for the rest of the year could come down to the two candidates who have already been running for the job next year: Rep. Ryan Smith (R-Bidwell) and Rep. Larry Householder (R-Glenford). Another possibility is that the caucus will select a placeholder speaker to finish out the year, and Rep. Dorothy Pelanda (R-Marysville), who is term-limited, has expressed interest in that role.

Rep. Smith has said he's confident he can win the speaker's chair when a vote is called. (See Gongwer Ohio Report, April 13, 2018)

He and Rep. Householder have both been supporting candidates in primary races in an effort to secure a majority in the next General Assembly. (See Gongwer Ohio Report, January 30, 2018)

If the race comes down to Rep. Smith and Rep. Householder, a likely factor in the race will be the results of the primary election, to be held a week before the speaker vote.

The caucus could also choose a placeholder speaker, likely a term-limited member. Rep. Pelanda said she has discussed the possibility that she run to finish out the rest of the year. Unlike the other hopefuls, she would be able to do so without the distraction of running in another election.

"I truly believe that it's in the best interest of the members of the Ohio House of Representatives that we have an interim leader to finish out the business of the 132nd General Assembly," she said in an interview.

She said she has not aligned herself with either of the other speaker candidates and said she has had "thoughtful, encouraging" conversations with fellow members about running.

"We've got three weeks until the election and the members will continue to be thoughtful about what is in the best interest going forward for this assembly," she said.

Coal Group, Farm Bureau Urge Panel To Maintain Industry Tax Exemptions

Existing tax breaks supporting the coal and agriculture sectors should be preserved, stakeholder groups told the Tax Expenditure Review Committee Wednesday.

The Ohio Coal Association and the Ohio Farm Bureau Federation were among a handful of interested groups arguing in favor of continuing certain tax exemptions as the panel considers whether to preserve or scrap them. (Testimony)

Their arguments are essentially the same - that their respective industries are experiencing trying times and therefore need all the assistance they can get.

OCA President Mike Cope said the coal industry is just now beginning to recover from the "relentless war on coal" waged by the Obama Administration.

"Any tax levied on the purchase of new equipment would be devastating to our recovering industry," Mr. Cope said. "State policy that could increase the cost of coal mining could translate into higher electricity bills for Ohio's consumers."

The tax credit Mr. Cope was referring to exempts tangible personal property used directly in mining. Memos from the Department of Taxation estimate that the break costs the General Revenue Fund $73.4 million in Fiscal Year 2018 and $74.3 million in FY 2019. (ODT Analyses)

The Farm Bureau, meanwhile, lobbied for the continuation of credits pertaining to tangible personal property used in agriculture and for the sales and installation of agricultural land tile and portable grain bins.

The former credit lowered GRF revenues by $331.1 million and $339.4 million in FY 2018 and 2019, ODT reported. The tile and grain bin concession has a smaller impact at just over $1 million in each of those years.

"The application of sales tax to input costs of a capital intensive, low profit industry such as agriculture would have significant and severe consequences," said Tony Seegers, the group's director of state policy. "Farm Bureau strongly believes the sales tax exemption must be preserved."

If lawmakers did away with those tax credits, Mr. Seegers said, the higher costs wouldn't immediately be passed onto consumers through costs. Instead, he said farmers themselves would be forced to swallow the change.

"Because prices are dictated by commodity exchanges and global demand, increased costs associated with applying sales tax to inputs will largely be eaten by farmers," he said. "Considering the profit margins we operate on, one can't help to think this would very likely drive some farmers out of business."

The Ohio Council of Retail Merchants submitted written testimony defending an exemption for tangible personal property used in storing, preparing and serving food. ODT estimates a GRF impact of about $34 million each fiscal year for the biennium due to that exemption.

"This exemption is vital to retailers engaged in providing food products to the general public, as well as to the public served by those retailers who benefit from lower prices as a result," the council argued.

Two other exemptions were on Wednesday's agenda but received no public feedback. They included sales of tangible personal property and services to electricity providers, and TPP used to produce printed materials. In Fiscal Years 2018-2019, those exemptions were expected to cost the GRF $699.9 million and $19.7 million respectively, according to ODT.

Wednesday's was the third overall meeting of the committee, which is tasked with reviewing all of Ohio's tax credits over the next eight years. The committee will meet again May 9 to discuss the remaining handful of sales and use tax breaks.

Chairman Sen. Scott Oelslager (R-N. Canton) said he anticipates the May meeting to be the committee's last this spring. The sales and use exemptions examined during the committee's meetings this year will form the basis of its first report this summer, he said.

"I think we're progressing in a manner that will help us make some decisions down the road and hopefully educate the people of Ohio who are watching," Sen. Oelslager said of the committee's work thus far.

The committee is expected to begin reviewing other exemptions heading into 2019 and has eight years to fully review all $9 billion-plus a year Ohio's tax credits. The panel has already looked at manufacturing, packaging and a handful of other exemptions. (See Gongwer Ohio Report, April 11, 2018)

In general testimony, Zach Schiller, research director for Policy Matters Ohio, told members the legislature should appropriate funding for staff to undertake a more detailed analysis of the genesis of specific credits and how they have been broadened over time.

He also bemoaned that even as the committee continues its review lawmakers are still proposing and considering new tax exemptions through legislation.

"Adding new special-interest breaks is ill-conceived when this committee has barely started looking at the tax exemptions and credits we have now," Mr. Schiller said. "When the General Assembly thinks about giving away tens of millions for new business tax breaks, it should consider whether we have the money to pay for them, and whether the funds would be better spent educating young Ohioans, cutting our high infant-mortality rate, or fighting the opioid epidemic."

Supreme Court Keeps In Place Rulings On Transfer Agreement, Autopsies

The Ohio Supreme Court on Wednesday denied several motions for reconsideration, including in two high-profile cases involving abortion and public records.

In one case, the court declined to reconsider its February ruling that found the Department of Health was justified in revoking the operating license of a Toledo abortion clinic for lack of a written transfer agreement with a "local" hospital.

In the ruling, the court found that Capital Care Network of Toledo violated state administrative code by inking a written transfer agreement with an Ann Arbor hospital, which the ODH deemed to not be local. (See Gongwer Ohio Report, February 6, 2018)

Ohio Right to Life President Mike Gonidakis called on the state to revoke the license of Toledo's only abortion clinic.

"Capital Care Network owes an enormous fine of $40,000 to the state of Ohio, based upon repeated violations of state law," he said. "The original Ohio Department of Health order remains in effect and in order to reopen, this abortion facility must reapply for a license and pay its fine before aborting anymore children."

However, in a statement of its own NARAL Pro-Choice Ohio called on the ODH to immediately reinstate the license for the clinic.

"This morning, a woman in Toledo woke up with the knowledge that she needed an abortion," Executive Director Kellie Copeland said. "There is a clinic in her community that can offer her safe and professional care. That clinic has met all state requirements to provide abortion services. John Kasich and Mike DeWine are standing in between that woman and this clinic, and they are violating her rights as they do so."

Shortly after the court's original decision, the clinic lined up a last-minute transfer agreement with ProMedica.

The court also declined to reconsider its December decision in which it ruled against two newspapers that sought to compel the release of the final, un-redacted autopsy reports of eight individuals murdered in a single night in April 2016 in a Pike County case that is still unsolved.

The divided court in a 4-3 decision found the records requested by the *Cincinnati Enquirer* and the *Columbus Dispatch* fall under the confidential law enforcement investigatory records exemption. (See Gongwer Ohio Report, December 14, 2017)

The newspapers had argued that under the law final autopsy reports do not qualify for the CLEIR exemption because a coroner is not a law enforcement official.

Justice Terrence O'Donnell and Justice Sharon Kennedy dissented with the ruling on the motion to reconsider.

In a less high-profile case, the court also declined to reconsider its decision not to accept jurisdiction in a case in which a commercial fishing operation alleged that the state's administrative code defining Lake Erie yellow perch management units is unconstitutionally vague. (See Gongwer Ohio Report, July 14, 2017)

High Court Clarifies Appellate Review Of Arbitration Appeals

When an appellate court reviews a lower court ruling on an arbitration decision it should conduct an independent review of the legal claims made on appeal, the Ohio Supreme Court ruled Wednesday.

In a unanimous decision authored by Justice Terrence O'Donnell, the high court determined appellate courts should accept findings of fact by trial courts that are not clearly made in error while reviewing the legal questions raised on appeal.

"When reviewing a trial court's decision to confirm, modify, vacate, or correct an arbitration award, an appellate court should accept findings of fact that are not clearly erroneous but should review questions of law de novo," Justice O'Donnell ruled.

The case stems from a dispute between the Portage County Board of Developmental Disabilities and one of its employees, the high court reported.

Patricia Byttner was hired to serve as an account clerk for the board with the understanding she would fill the role of a bus driver or bus aide in emergency situations.

After her hiring, Ms. Byttner refused a bus aide assignment, citing a pending knee surgery.

Two months later, the board amended her job description, leading to the union representing her to file a grievance. An arbitrator sided with Ms. Byttner and the union.

The board then successfully asked the Portage County Court of Common Pleas to vacate the ruling.

The union challenged the trial court decision at the Eleventh District Court of Appeals, which reinstated the arbitrator's decision.

However, the decision conflicted with other appellate court rulings, leading the case to the high court.

"In conformity with our resolution of the certified question, we recognize that the court of appeals conducted a proper de novo review of the trial court's decision in this case vacating the arbitration award, reversed its decision, reinstated the arbitration award, and therefore we affirm its judgment," Justice O'Donnell wrote for the court.

In his decision, Justice O'Donnell noted that nine of the state's appellate courts applied a de novo review while three applied an "abuse of discretion" review.

Tenth District Court of Appeals Judge Lisa Sadler sat in on the case for former Justice Bill O'Neill.

Cordray Campaign Pledges To Protect, Expand Veterans Benefits

Lieutenant governor candidate Betty Sutton on Wednesday unveiled her campaign's plan to safeguard health care benefits and create new employment protections for the state's servicemembers and veterans.

Ms. Sutton, the Democratic running mate of Rich Cordray, and former gubernatorial candidate Connie Pillich unveiled the campaign's policies regarding members of the armed forces at a press conference at the Statehouse Veterans Plaza.

The former congresswoman said the state has not done enough to support the men and women who are serving or have served in the military. She said enhancing services for veterans and better connecting them with existing resources would be a "top priority" in Cordray's administration.

"Too often our respect and admiration simply hasn't been matched by tangible action to help our veterans and servicemembers," she said.

The campaign's plan calls for the state to better fund county veterans services commissions to help them assist veterans making medical claims, offer incentives for employees who hire veterans with mild traumatic brain injuries, and protect the state's expansion of Medicaid for veterans who do not qualify for VA benefits.

Ms. Pillich, the head of the campaign's veterans policy team, said the "No. 1 concern" among veterans she has talked to throughout the state is health care. She said the Cordray campaign's plan would safeguard and expand important resources for servicemembers.

"Ohio veterans need much more than a specialty license plate," she said.

The former Ohio House member and U.S. Air Force veteran said the campaign also is proposing to include a box for veterans to check on state tax returns to allow the governor's office to identify them and connect them with available resources.

The plan also suggests the state protect the jobs of Army National Guard members who have been activated and allow spouses who lose their jobs because of a servicemember's transfer to collect unemployment benefits.

Ms. Sutton said she and her running mate also would make it a priority to take combat "predatory lenders" who target veterans.

"I can think of no leader with stronger credentials to do that than Rich Cordray," she said, citing her running mate's tenure as head of the Consumer Financial Protection Bureau.

Ms. Sutton, who previously served on the U.S. House Armed Services Committee, also pointed to Mr. Cordray's work on a successful 2009 ballot issue to authorize bonuses for veterans of conflicts in Afghanistan, Iraq and the Persian Gulf as evidence of his support for servicemembers.

"We owe veterans an enormous debt of gratitude, but our gratitude must be matched by tangible action by state government to improve the lives of veterans, servicemembers and military families," Mr. Cordray said in a statement. "Betty and I will fight every day in office to honor those who have served and provide them with the support they need to thrive in Ohio."

Obhof OK With Legislative Look At E-School Enrollment Rules; OSU Joins Anti-Poverty Effort; Portman Bill Targets Tech Teacher Training; Auditor Issues Bus Study...

Senate President Larry Obhof on Wednesday said setting standards for verifying e-school enrollment falls within the legislature's purview after a whistleblower's claims thrust a shuttered charter school back into the spotlight.

The chamber leader said after a nonvoting session that the body "should take a look" at how the state measures enrollment and funds such schools rather than fully deferring to ODE.

"When the legislature's able to do things or has the responsibility for doing things, it should be the legislature, not an administrative agency, that does that," he said.

The Associated Press first reported an employee of the Electronic Classroom of Tomorrow told Department of Education officials last year that the school demanded workers manipulate attendance figures after the state moved to recoup $60 million in payments. Within hours, the former employee's claim became an issue among candidates for attorney general and auditor. (See Gongwer Ohio Report, April 24, 2018)

Despite backing an examination of the issue by the legislature, Sen. Obhof (R-Medina) said he does not support "micromanaging all of the fine-tuned details" of the state's enrollment-verification process.

A bill (HB 611) sponsored by Rep. Keith Faber (R-Celina) and Rep. Kristina Roegner (R-Hudson) that would tie state payments to e-schools to the use of verifiable software that tracks attendance, class size and participation was introduced last week in the House.

Alliance for the American Dream: Ohio State University has received a $1.5 grant after a philanthropic organization selected the school to participate in an effort aimed at bolstering the middle class.

Schmidt Futures, a group founded by former Alphabet Executive Chairman Eric Schmidt, announced this week it added OSU to its Alliance for the American Dream. The effort seeks to increase economic opportunities for working Americans and reduce poverty.

"We are delighted to announce that Ohio State will act as an inaugural partner in the Alliance for the American Dream," Mr. Schmidt said in a statement. "When I was in Columbus last December, I saw firsthand the energy and vibrancy of the campus and region. Columbus is a perfect place to find great, fresh ideas. We are delighted to support them as they fuel an innovation engine to help distressed communities and expand the middle class."

As part of the collaborative project, OSU will receive $1.5 million in funding to engage business, community and government leaders in "in a robust brainstorming process," according to a news release from the school.

"As a modern land-grant university, Ohio State is committed to expanding opportunity, unlocking talent and increasing economic vitality," OSU President Michael V. Drake said in a statement. "We are

absolutely thrilled to join the Alliance and to partner with individuals and communities on this important and timely endeavor. It's 'The Columbus Way' in action."

Teacher training bill: U.S. Senator Rob Portman announced the introduction of a bill aimed at establishing a grant program to support training for career and technical education teachers

"Quality CTE teachers play a key role in expanding access to high quality programs and making sure more students and parents recognize the value of a CTE education - all of which helps lead to more and better job opportunities for students," Sen. Portman said in a statement. "I'm proud to introduce this bipartisan bill to ensure that we have better prepared teachers for this generation and generations to come."

The Creating Quality Technical Educators Act would provide funding for one-year residencies at schools for potential career and technical educators.

Sen. Portman (R-Terrace Park) is co-chairman of the Career and Technical Education Caucus with Sen. Tammy Baldwin (D-WI) and Sen. Tim Kaine (D-VA). The co-chairs introduced the legislation alongside Sen. Shelley Moore Capito (R-WV).

The Alliance for Excellent Education, the American Federation of Teachers and the Association for Career and Technical Education have expressed support for the measure.

Feasibility study: Belmont County school districts could save money by combining their efforts to maintain school buses, according to a study called the "first of its kind" by the state auditor's office.

The Bellaire Local School District, the Bridgeport Exempted Village School District, the Shadyside Local School District and the St. Clairsville-Richland City School District requested the state perform the study after seeing the number of bus riders decrease in recent years.

The study found the districts could operate more efficiently and save money by combining some maintenance efforts. Legislation (HB5) that took effect in 2016 gave the auditor's office the power to study the feasibility of potential efforts to share services among local governments.

"Ohio has thousands of local government entities, which has the advantage of keeping government close to the people, but the drawback is duplication of effort," State Auditor Dave Yost said in a statement. "Sharing services can keep government close to the people while reducing redundant administration, facilities and equipment. This saves money and improves efficiency for taxpayers. It also is a way to continue providing an adequate level of service even if costs rise or budgets shrink."

Space Embarks On Tour To Highlight Corruption; Cordray Launches New Ad; Yuko Gets SEIU Backing...

Zack Space announced that he is embarking on a two-day, five-city tour detailing the "corrupt culture on Capitol Square."

The state auditor hopeful in a statement cited the Electronic Classroom of Tomorrow scandal and the resignation of former Speaker Cliff Rosenberger as examples of the "the pervasive culture of corruption."

"We must take state government back from the self-interested incumbents and campaign contributors who put their special interests above the needs of ordinary Ohioans," he said in a statement. "That's why I am calling for a wide-ranging criminal investigation into ECOT and for the politicians who aided and abetted this scam to donate every cent of campaign contributions received from ECOT founder Bill Lager and his associates to charities supporting Ohio public schools."

The tour included Wednesday stops in Youngstown and Steubenville and will head to events in Dayton, Toledo and Lima on Thursday.

New Ad: Democrat Richard Cordray is up with his second television ad in his gubernatorial campaign.

In "Save," the former director of the Consumer Financial Protection Bureau touts his record of protecting consumers.

"As treasurer, Cordray safeguarded your tax dollars. As attorney general he recovered $2 billion that Wall Street stole," the narrator says in the 30-second spot. "That's why President Obama chose him to be our nation's top consumer watchdog."

SEIU Backing: Senate Minority Leader Kenny Yuko, who faces a primary challenge from Rep. John Barnes (D-Cleveland), announced on Wednesday the Service Employees International Union District 1199 WV/KY/OH is backing his candidacy.

In announcing the endorsement Anthony Caldwell, director of public affairs, in a statement cited the Richmond Heights Democrat's three-decade career as a union organizer.

"Yuko's career as a 30-year union organizer reinforces and guides his principles to support the people of his district and determination to help those who are most vulnerable. He wants families in the 25th Senate District and across Ohio to earn fair wages, a quality public education, and access to healthcare coverage," he said.

Union Endorsement: Franklin County Recorder Danny O'Connor picked up another endorsement in his bid for the Democratic nomination in the 12th Congressional District.

The Communications Workers of America Local 4502 announced Wednesday that it is backing his candidacy. President David McCune in a statement said Mr. O'Connor will fight to protect working families.

"Danny has a passion for issues that affect hard working men and women such as creating economic opportunity and jobs for Ohio, improving our education system, and safeguarding our voting rights and the commitment to work for families," he said.

Farm Bill: The Ohio Farmers Union announced Wednesday its opposition to the U.S. House's version of the farm bill.

President Joe Logan said the proposal "turned a blind eye toward the urgent needs of farmers for a strong safety net" and "to the nutrition needs of America's least fortunate in both rural and urban communities."

"The Congress and administration have clearly demonstrated a willingness to explode the federal budget deficit by giving a $1.5 trillion tax cut to wealthy corporations and individuals," he added. "When rural America asks for a far more modest budget request, they can't manage to find a way to lend a hand."

BWC Rebate: In the wake of the Bureau of Workers' Compensation's announcement that it is issuing an employer premium rebate to the tune of $1.5 billion, the Ohio Association of Justice is questioning a challenge to an appellate court ruling that found some "scheduled loss awards" should be paid in lump sums.

BWC was paying those awards to workers who suffer amputations or loss of use due to industrial injuries on a biweekly basis.

"It is time to ask, when did the Ohio workers' compensation system stop being about injured workers?" John Van Doorn, government affairs director, said in a release. "We are all in favor of job creation in this state, but let's share some of the BWC's financial surplus with the injured workers who the system was constitutionally created to protect."

Advocate Seeks KY Seat: Longtime Ohio Statehouse fixture Col Owens is looking to enter the other side of the legislative political realm - just in another state.

Mr. Owens, who served for 30 years as senior attorney for the Legal Aid Society of Southwest Ohio and was involved in Advocates for Ohio's Future and other groups backing health and human services funding, is running as a Democrat in Kentucky's 69th House District.

The lifelong Kentucky resident's candidacy is the subject of a fundraiser next month at the home of former Ohio Rep. Ted Celeste and wife Bobbie, 1230 Oakland Ave. in Grandview Heights.

Those interested in attending or seeking more information on the event, set for 5:30-7 p.m. May 10, should RSVP to Cathy Levine at cathyjlevine@gmail.com or 614-313-7478.

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For questions about Gongwer bill tracking services, contact Gongwer at gongwer@gongwer-oh.com or 614.221.1992.

Governor's Appointments

Columbus State Community College Board of Trustees: Rick Ritzler of Galena (Delaware Co.) has been appointed to the for a term beginning April 25, 2018, and ending August 31, 2023.

Waterways Safety Council: Amy Dingle of Dayton (Montgomery Co.) has been appointed to the for a term beginning April 25, 2018, and ending January 30, 2021.

Supplemental Agency Calendar

Friday, April 27

STEM Designation Committee, 25 S. Front St., Columbus, 9:30 a.m.

Wednesday, May 9

Veterinary Medical Licensing Board, Rm. 1914, 77 S. High St., Columbus, 8:30 a.m.

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Scott Miller, President | Kent Cahlander, Editor | Mike Livingston, Dustin Ensinger, Jon Reed, Tom Gallick, Staff Writers

Click the after a bill number to create a saved search and email alert for that bill.

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Daily Activity Planner for Thursday, April 26

Legislative Committees

No legislative committees scheduled.

Agency Calendar

BWC Board of Directors, 30 W. Spring St., Room 3 on Level 2, Columbus, 8 a.m.
Facilities Construction Commission, Rm. 121, Statehouse, Columbus, 1:30 p.m.

Event Planner

Deadline to file pre-primary campaign finance reports

Rep. Glenn Holmes (D-McDonald) fundraiser, Vernon's Italian Ristorante, 720 Youngstown-Warren Road, Niles, 5 p.m., (Event Sponsor $1500, Supporter $1000, Friend $500, Table Sponsor $300, Individual $60 to Committee to Elect Glenn Holmes)

Rep. Nathan Manning (R-N. Ridgeville) fundraiser, Berry's Restaurant, 15 W. Main Street, Norwalk, 5 p.m., (Sponsor: $250 to Nathan Manning for Ohio)

Rep. Anne Gonzales (R-Westerville) fundraiser, Aloft Columbus Westerville, 32 Heatherdown Drive, Westerville, 5:30 p.m., (Sponsor: $1,000 | Host: $500 | Guest: $250 to Citizens for Anne Gonzales)

Rep. Hearcel Craig (D-Columbus) fundraiser, The Lincoln Caf□, 740 E. Long St., Columbus, 5:30 p.m., ($250, $100, $50, $25 to Friends of Hearcel F. Craig)

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Scott Miller, President | Kent Cahlander, Editor | Mike Livingston, Dustin Ensinger, Jon Reed, Tom Gallick, Staff Writers

Alexander, Steven

From: Advocates for Ohio's Future <ADVOCATESFOROHIO=GMAIL.COM@mail60.us4.mcsv.net> on behalf of Advocates for Ohio's Future <ADVOCATESFOROHIO@GMAIL.COM>
Sent: Tuesday, April 24, 2018 9:00 AM
To: Alexander, Steven
Subject: New Director at Advocates for Ohio's Future!

View this email in your browser

Advocates for Ohio's Future is excited to Welcome new Coalition Manager Kelsey Bergfeld!

April 24, 2018

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For Immediate Release

COLUMBUS, OH – Advocates for Ohio's Future (AOF) is pleased to announce that Ms. Kelsey Bergfeld will become the organization's Coalition Manager on May 1.

AOF is a statewide coalition of nearly 500 local and statewide organizations that promote health and human service solutions so all Ohioans live better lives.

"I think Kelsey brings considerable advocacy and legislative experience to Advocates for Ohio's Future," said Lisa Hamler-Fugitt, the Executive Director of the Ohio Association of Food Banks and a co-chair of AOF.
Bergfeld most recently worked as the Legislative Liaison for SEIU District 1199 WV/KY/OH, and prior to that, was a Senior Legislative Aide for State Senator Tom Sawyer.

"We're excited about the experiences that Kelsey brings to the position. She has a wealth of knowledge in the legislative process and Ohio's health and human services system. Kelsey will be a great addition to our AOF team as we work to make sure all Ohioans live better lives. We look forward to her leading AOF into the future," said Mark Davis, President of Ohio Provider Resource Association and a co-chair of AOF.

In Bergfeld's new role, she will provide leadership in AOF's coalition work and policy advocacy. She will also work to develop legislative strategy for AOF and its members.

"Kelsey's understanding of the legislative landscape, certainly around health and human services programs, is very strong, and I think she is going to be a really confident leader and a strong voice for our public policy agenda and representing our diverse coalition partners," said Hamler-Fugitt.

For more information on AOF, find us on Twitter at @Advocates4Ohio, on Facebook at Facebook.com/advocatesforohio or visit our website www.advocatesforohio.org.

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Alexander, Steven

From: Kaiser Health News <emails@kaiserhealthnews.org>
Sent: Wednesday, March 21, 2018 9:42 AM
To: Alexander, Steven
Subject: KHN Morning Briefing: March 21, 2018

In This Edition:

KAISER HEALTH NEWS ORIGINAL STORIES

HEALTH LAW

From Kaiser Health News:

KAISER HEALTH NEWS ORIGINAL STORIES

1. Research Misconduct Allegations Shadow Likely CDC Appointee

Critics say the Trump administration has failed to properly vet its leading candidate to lead the CDC as they point to a pattern of "ethically and morally questionable behavior." (Marisa Taylor, 3/20)

2. Clash Over Abortion Hobbles A Health Bill. Again. Here's How.

As Congress considers a bipartisan bill to help hold down premium prices on the health law's marketplaces, a long-standing fight over abortion reappears. (Julie Rovner, 3/21)

3. Reporter's Notebook: The Tale Of Theranos And The Mysterious Fire Alarm

Health care tech startup Theranos was riding high back in 2014. But when a reporter raised questions, its media reps circled the wagons. (Jenny Gold, 3/21)

4. Are There Risks From Secondhand Marijuana Smoke? Early Science Says Yes.

Scientists are finding that, just as with secondhand smoke from tobacco, inhaling secondhand smoke from marijuana can make it harder for arteries to expand to allow a healthy flow of blood. (Marissa Ortega-Welch, KALW, 3/21)

5. Political Cartoon: 'Dry Run?'

Kaiser Health News provides a fresh take on health policy developments with "Political Cartoon: 'Dry Run?'" by Bob and Tom Thaves.

Here's today's health policy haiku:

WOMEN IN MEDICINE SHOUT #METOO

Health care industry
Not immune from "Me Too" deeds.
Is there no vaccine?

- Ernest R. Smith

If you have a health policy haiku to share, please Contact Us and let us know if you want us to include your name. Keep in mind that we give extra points if you link back to a KHN original story.

Summaries Of The News:

6. Insurers' Financial Well-Being Has Improved After Rocky First Years Of Health Law, Report Finds

Industry officials, however, say the health of a company can't be judged by stock prices alone, and many of the biggest publicly traded companies have pulled back on the individual insurance market. Meanwhile, Democrats are getting ready to use expected premium increases against Republicans in the midterms.

The Wall Street Journal: White House Report Says Insurers Doing Well, Increasing ACA Subsidy Doubts
Health insurers have largely adjusted to the impact of the 2010 Affordable Care Act, the White House will say in an economic report Wednesday, a finding that will likely undercut lawmakers' efforts to secure federal funds to blunt potential premium increases for the coming year. Republicans, Democrats and the White House are negotiating the provisions of a major spending bill that must pass by Saturday or risk a government shutdown. The insurance payments are part of those discussions. (Radnofsky, 3/21)

The Hill: Dems Aim To Turn ObamaCare Hikes Into Election Weapon
Democrats are gearing up to blame Republicans for ObamaCare premium increases after the likely failure of an effort to stabilize the law in this month's government funding package. The premium hikes for ObamaCare will likely be announced in October, just a month before a midterm election where Democrats are hoping to win back the House and Senate. (Sullivan, 3/21)

In other health law news —

New Orleans Times-Picayune: Donelon Sees High Risk For Louisiana In Trump Health Insurance Proposal
State Insurance Commissioner Jim Donelon cautioned that a proposal by President Donald Trump to allow the purchase of health insurance policies across state lines could be "catastrophic" for some Louisiana residents unless the state has the authority to regulate the carriers. Republican U.S. senators filed a bill Monday (March 19) that

would require the federal Department of Health and Human Services to issue regulations allowing insurers to sell plans across state lines. (3/20)

CAPITOL HILL WATCH

7. Prospects Dim For Market Stabilization Bill As Congress Hustles To Avoid Shutdown Deadline

Senate Majority Leader Mitch McConnell (R-Ky.) is open to bringing the bill to the Senate floor but it's unclear whether McConnell would present the bill as a stand-alone or as an amendment to the spending omnibus.

Modern Healthcare: CSRs, Reinsurance May Get Another Shot In The Senate, But Chances Are Slim
The Senate is facing what could be the last chance to pass a market stabilization measure as odds of passage look dim with increasingly politicized discussion over the legislation. GOP leaders in the House scuttled the measure Monday night. Sen. Susan Collins (R-Maine), who along with Sen. Lamar Alexander (R-Tenn.) has championed a bill that would fund cost-sharing reduction payments and a $30 billion reinsurance pool, said Tuesday that she sees Friday at midnight as the last opportunity to get the measure through. That's when Congress must pass an omnibus spending bill to avert a government shutdown. (Luthi, 3/20)

CQ: Senators Weigh Next Steps On Health Insurance Package
Talks between senators about a package meant to lower health insurance premiums next year continued Tuesday, although its inclusion in the fiscal 2018 omnibus spending bill appears to be a long shot. Sen. Patty Murray, D-Wash., told reporters on Tuesday she is still talking with Sen. Susan Collins, R-Maine, about a health care stabilization package. The spending bill is expected to be filed before the end of the day in the House, where Republicans say a stabilization package will not be part of the bill. The package would include funding for states to set up reinsurance programs or high-risk pools to help with the expenses of high-cost patients and restore funding for cost-sharing reduction subsidies, which President Donald Trump ended. (McIntire, 3/20)

In related news —

Kaiser Health News: Clash Over Abortion Hobbles A Health Bill. Again. Here's How. The Affordable Care Act very nearly failed to become law due to an intraparty dispute among Democrats over how to handle the abortion issue. Now a similar argument between Democrats and Republicans is slowing progress on a bill that could help cut soaring premiums and shore up the ACA. At issue is the extent to which the Hyde Amendment — language commonly used by Congress to prohibit most federal abortion funding — should be incorporated into any new legislation affecting the health law. (Rovner, 3/21)

Politico Pro: Omnibus Scramble Could Jeopardize Pharma's Doughnut Hole Change Lawmakers are considering including a ban on "pay-for-delay" drug patent settlements in the omnibus spending bill, multiple industry lobbyists told POLITICO. The move, long opposed by both generic and branded drug industries, may be complicating brand-name drugmakers' goal of using the spending package to reduce their share of Medicare Part D coverage gap payments. (Karlin-Smith and Haberkorn, 3/20)

SUPREME COURT

8. Supreme Court Justices Signal Skepticism Over 'Crisis Pregnancy Centers' Law

During arguments, justices from across the ideological spectrum questioned whether the California law, that requires centers licensed by the state to post notices that free or low-cost abortion, contraception and prenatal care are available, singles out clinics run by antiabortion groups.

The New York Times: Supreme Court Warily Eyes California Law Involving Abortion And Free Speech
A California law that requires "crisis pregnancy centers" to provide information about abortion met a skeptical reception at Supreme Court arguments on Tuesday. The centers, which are often affiliated with religious groups, seek to persuade women to carry their pregnancies to term or to offer their offspring for adoption. The law requires centers licensed by the state to post notices that free or low-cost abortion, contraception and prenatal care are available to low-income women through public programs, and to provide the phone number for more information. (Liptak, 3/20)

Politico: Supreme Court Hostile To Part Of California Law Aimed At 'Crisis Pregnancy Centers'
A surprisingly broad array of justices expressed serious concerns that the Reproductive FACT Act intrudes on First Amendment rights, by requiring such centers to include in their ads a state-provided notice in as many as 13 languages offering contact information about abortion services and other options. Justice Anthony Kennedy, a pivotal vote to uphold a constitutional right to abortion, was openly hostile to that provision. And even liberals like Justices Sonia Sotomayor and Elena Kagan raised doubts about that portion of the law. (Gerstein, 3/20)

The Wall Street Journal: Justices Press California Over Law Challenged By Antiabortion Groups
Justice Samuel Alito suggested the law may have been designed to blunt the antiabortion message that such centers seek to deliver. While ostensibly covering hundreds of facilities across the state, the law contains many "crazy exemptions" that all point the same way, he said. If "it turns out that just about the only clinics that are covered by this are pro-life clinics," couldn't the court "infer intentional discrimination?" he said. (Bravin, 3/20)

Bloomberg: Supreme Court Justices Cast Doubt On California Abortion-Disclosure Rules
The justices pressed the clinics' lawyer, Michael Farris, to square his position with a 1992 Supreme Court decision that upheld "informed consent" requirements imposed on doctors who perform abortions. Justice Stephen Breyer suggested that abortion-rights states should have the same ability to require disclosure by clinics that oppose the procedure. "What is sauce for the goose is sauce for the gander," he said. But other justices signaled they were more skeptical of California's law. (Stohr, 3/20)

San Francisco Chronicle: Supreme Court Questions Parts Of California Law Requiring Abortion Notification
Justice Anthony Kennedy, a Californian and moderate conservative who has cast the deciding vote in past abortion cases, criticized a provision of the law that requires clinics offering reproductive care, with no doctor on their staff, to inform clients they are unlicensed by the state. Noting that the disclosure provision applies to advertising,

Kennedy said it would require a clinic that has paid for a billboard that simply said "Choose Life" to also include the notification. (Egelko, 3/20)

ADMINISTRATION NEWS

9. Senator Blasts Possible CDC Nominee For 'Pattern Of Morally Questionable Behavior' As Past Research Controversy Resurfaces

Sen. Patty Murray (D-Wash.) sent a letter to President Donald Trump voicing concerns about Dr. Robert Redfield, who is being vetted to lead the CDC. Redfield was investigated in 1994 for misrepresenting data to promote an AIDS vaccine, though the probe concluded that the errors did not constitute misconduct. Earlier in his career, Redfield also advocated for policies like mandatory patient testing for HIV and for segregating HIV-positive Army soldiers.

The Hill: Top Senate Dem Raises Concerns Over Potential CDC Pick
A top-ranking Senate Democrat said she was concerned about the Trump administration's reported choice to lead the Centers for Disease Control and Prevention (CDC). Sen. Patty Murray (D-Wash.), ranking member of the Senate Health, Education, Labor and Pensions Committee, sent a letter to President Trump, saying she was worried about Robert Redfield's lack of public health experience, as well as his controversial past as an AIDS researcher. (Weixel, 3/20)

Kaiser Health News: Research Misconduct Allegations Shadow Likely CDC Appointee
President Donald Trump's likely pick to lead the Centers for Disease Control and Prevention is facing significant criticism because of a 20-year-old controversy over shoddy HIV research. The Army in 1994 acknowledged accuracy issues with HIV vaccine research led by Dr. Robert Redfield, who is expected to head the CDC, but concluded at the time that the data errors did not constitute misconduct. (Taylor, 3/20)

In other administration news —

NPR: Religious Freedom Counts First In This HHS Civil Rights Division
When Roger Severino tells his story, discrimination is at its heart. "I did experience discrimination as a child. And that leaves a lasting impression," he tells me. Severino directs the Office for Civil Rights in the U.S. Department of Health and Human

Services. When I meet with him at his office in the shadow of the Capitol, he talks about his childhood as the son of Colombian immigrants growing up in Los Angeles. (Kodjak, 3/20)

10. Azar's Emphasis On Price Transparency Cheers Advocates Despite Lack Of Concrete Details

But experts say the cost-reduction potential of greater price transparency is limited because only a small percentage of total U.S. healthcare spending is on services for which patients truly can comparison shop.

Modern Healthcare: Azar Demands Price Transparency, But How Will He Achieve It?
Increasing price transparency was part of a "four shifts" agenda Azar laid out for transforming U.S. healthcare into a more competitive, value-based system that costs less. But he faces a hard slog to make prices and out-of-pocket costs public, particularly since many providers and pharmaceutical companies have resisted even while saying they support the concept. They argue it's the job of health plans to tell their members how much they will owe.In addition, experts say the cost-reduction potential of greater price transparency is limited because only a small percentage of total U.S. healthcare spending is on services for which patients truly can comparison shop. (Meyer, 3/19)

Bloomberg: Trump's Health Chief Wants To Change How Doctors Do Business
In his short time on the job, [Alex] Azar has embraced many of Obama's objectives around lowering costs and improving quality, but with a Trumpian impatience to upend the established order. He called recent experiments to bring down costs "lackluster" and declared his intention to "fundamentally reorient how Medicare and Medicaid pay for care." Those programs spent $1.2 trillion in 2016. Add in private health plans, which often follow Medicare's lead, and the health sector accounts for 18 percent of the U.S. economy. (Tozzi, 3/21)

11. NIH To Investigate Claims That Officials Courted Alcohol Industry To Fund Drinking Study

Scientists had suggested that the study would support the benefits of moderate drinking, according to reports, when soliciting donations from private companies.

The New York Times: N.I.H. To Investigate Outreach To Alcohol Companies
The National Institutes of Health will examine whether health officials violated federal policy against soliciting donations when they met with alcohol companies to discuss funding a study of the benefits of moderate drinking, Dr. Francis Collins, the institutes' director, said on Tuesday. Dr. Collins also will ask outside experts who are part of a standing advisory committee to review the design and scientific methodology of the 10-year government trial, which is already underway, an N.I.H. spokeswoman said. (Rabin, 3/20)

The Washington Post: NIH Will Examine Ethics Of Its Study On The Health Effects Of A Daily Glass Of Wine
The inquiry, announced by NIH Director Francis Collins, responds to a recent New York Times article that said a pair of outside scientists, including one who became the study's principal investigator, and an NIH official asked liquor companies that stand to benefit from the research to help pay for it. The Times story, relying in part on emails and travel vouchers obtained under the Freedom of Information Act, said the scientists "pitched" the idea of the study at meetings in three cities with beverage-industry executives and an industry trade group in 2013 and 2014. (Goldstein, 3/20)

12. Trump's Plan To Use Death Penalty To Curb Opioid Epidemic Is Already Legal

But federal prosecutors have never used that power to execute drug dealers in the 24 years since the law was signed.

Politico: Trump Can Execute Drug Dealers Already
The state execution of drug smugglers that President Donald Trump has pushed for as part of his plan to combat the opioid crisis is already legal under a 1994 law passed at the height of the crack cocaine epidemic. But in 24 years, federal prosecutors have never once used it. They hardly need to, considering the draconian penalties already available for punishing convicted drug smugglers. (Allen, 3/20)

New Orleans Times-Picayune: Death Penalty For Drug Dealers? 'Certainly Up For Debate,' Louisiana AG Says
President Donald Trump's proposal to use the death penalty on some convicted drug dealers as part of his plan to combat opioid addiction and overdose deaths is worth considering, Louisiana Attorney General Jeff Landry said. Speaking a press conference Tuesday (March 20) at the New Orleans Police Department's Gentilly station, Landry said the idea "is certainly up for debate." The attorney general joined leaders from the NOPD, St. Bernard Sheriff's Office, New Orleans Health Department and Blue Cross Blue Shield of Louisiana at NOPD's 3rd District station to speak to reporters about the placement of new drug drop-off boxes throughout the New Orleans metro area that allow residents to dispose of unused prescription medication. (Lane, 3/20)

In other news on the crisis —

Stat: NIH: Dozens Of Drug Makers Interested In Effort To Address Opioid Epidemic
Francis Collins, the director of the National Institutes of Health, said Tuesday that the agency is nearing a formal announcement of a public-private partnership aimed at funding research to help address the opioid crisis. Despite a preliminary announcement in September, the partnership has not yet been rolled out formally. Its professed aims include developing non-addictive painkiller alternatives to opioids, new forms of medication-assisted therapy for addiction treatment, and in the long term even vaccines that would insulate individuals from the effects of heroin and fentanyl use. (Facher, 3/20)

The Associated Press: DOJ Shares Painkiller Sales Data Amid Opioid Lawsuit Talks
The U.S. Department of Justice has shared some federal data about prescription painkiller sales to help with settlement talks between local governments and drug companies targeted in hundreds of lawsuits over the opioid epidemic. The department previously agreed to release certain data on the grounds it not be circulated publicly and be returned or destroyed when the litigation is finished. (3/20)

McClatchy: Cities Seek Supervise Intravenous Drug Use Despite DEA
A handful of cities could soon face a legal showdown with the Trump administration over their efforts to open "supervised injection facilities" where drug addicts can shoot

up with powerful illegal drugs while trained personnel stand by to prevent fatal overdoses. (Pugh, 3/20)

MARKETPLACE

13. Incoming AHIP President Wants To Focus On Affordability In Ever-Changing Health Landscape

Modern Healthcare talks with Matt Eyles, who will take the reins of the insurance lobbying group from Marilyn Tavenner on June 1.

Modern Healthcare: New AHIP Head Eyles Talks Priorities, Short-Term Health Plans And Megamergers
The insurance industry's dominant lobbying group America's Health Insurance Plans last week named Matt Eyles as its next president and CEO, taking over from Marilyn Tavenner on June 1. Eyles, who is currently AHIP's chief operating officer, previously held roles at D.C.-based consultancy Avalere Health, Coventry Health Care (now part of Aetna), and drugmaker Eli Lilly and Co. Modern Healthcare insurance reporter Shelby Livingston caught up with Eyles to talk about his priorities for the trade group, the federal government's move to expand short-term plans, and the recent wave of proposed megamergers between insurers and nontraditional partners. (Livingston, 3/20)

14. Video Footage Emerges Of Theranos' Mysterious Second-In-Command

Despite being Theranos' No. 2 executive, there's little trace of Sunny Balwani's image on the internet. But newly found footage shows Balwani giving a pitch for the company in 2014.

Stat: Theranos's Mystery Man Revealed: Footage Of Sunny Bawlani Was Hiding In Plain Sight
The day after the story came out, though, an eagle-eyed sleuth on Twitter pointed us to something better: Video footage of Balwani talking up Theranos in front of an Arizona legislative committee in March 2014. (That was around the time Theranos, then at its peak valuation of $9 billion, started opening testing centers in Walgreens pharmacies in

Arizona.) Donning a dark suit and tie and a blandly corporate affect, Balwani gave an 11 1/2-minute pitch that is vintage pre-scandal Theranos: He talked about working on "something that we believe is magical." He cited glowing testimonials from patients whose blood tests, we would later learn, were not being processed the way Theranos had promised. (Robbins, 3/20)

In other Theranos news —

Kaiser Health News: Reporter's Notebook: The Tale Of Theranos And The Mysterious Fire Alarm
It was November 2014, and I was working on a feature story about a buzzed-about blood-testing company in Silicon Valley that promised to "disrupt" the lab industry with new technology. The company, Theranos, claimed its revolutionary finger-prick test would be a cheap and less painful way to screen for hundreds of diseases with just a few drops of blood. Old-fashioned venous blood draws, where the patient watches as vial after vial of blood is collected, would quickly become obsolete, Theranos promised. (Gold, 3/21)

PHARMACEUTICALS

15. Novartis Sales Reps To Testify They Plied Doctors With Meals, Booze In Exchange For Prescription Promises

Numerous sales representatives are expected to testify against the company, the government revealed after Novartis asked a judge to rule that there was insufficient proof to move forward.

Stat: Ex-Novartis Sales Reps To Testify They Got Prescriptions By Wooing Doctors
Former Novartis sales reps from around the U.S. are expected to testify they were "essentially buying" prescriptions in exchange for providing doctors with paid speaking engagements, fancy meals, and alcohol in a closely watched lawsuit that is being pressed by the federal government. And both doctors and sales reps are expected to testify that payments were made for speaking engagements that never took place, and that many of these events had little to no educational content, but were really just

schmoozefests, according to a court filing on Monday by federal prosecutors. (Silverman, 3/20)

Bloomberg: Novartis Sales Reps Will Testify About Lavish Meals, U.S. Says
One sales representative said he and his colleagues were "essentially buying scripts" by providing health-care providers across the country with perks, including paid speaking opportunities at events with "little to no educational content," prosecutors said in a filing Monday in federal court in Manhattan. The government sought to highlight the depth of its evidence after Novartis had asked a judge to rule that there was insufficient proof to move forward. The government urged U.S. District Judge Paul Gardephe to reject the request and set a trial date. (Larson, 3/20)

For more news on high drug costs, check out our weekly feature, Prescription Drug Watch, which includes coverage and perspectives of the issue.

WOMEN'S HEALTH

16. Judge Temporarily Blocks Mississippi's 15-Week Abortion Ban

"The Supreme Court says every woman has a constitutional right to 'personal privacy' regarding her body," U.S. District Court Judge Carlton Reeves. Abortion news comes out of Idaho and Iowa, as well.

Reuters: Mississippi's New Law Restricting Abortion Blocked By Judge For 10 Days
A U.S. federal judge on Tuesday temporarily blocked a Mississippi law that enacted the tightest restrictions on abortion in the United States, in a ruling handed down a day after the governor signed the measure. The Mississippi law would prohibit abortion after 15 weeks of gestation, with some exceptions. It went into effect immediately after Republican Governor Phil Bryant signed it on Monday. State law previously banned abortion at 20 weeks after conception, in line with limits in 17 other states. (Dobuzinskis, 3/20)

The Hill: Judge Blocks Mississippi Law Banning Abortions After 15 Weeks
Mississippi Gov. Phil Bryant (R) signed the bill — the nation's most restrictive abortion ban — into law earlier this week. The law bans abortions after 15 weeks of pregnancy, down from a 20-week restriction already on Mississippi's books. The measure took

effect immediately. It featured some exceptions, including if a woman's life or a "major bodily function" is threatened or if the fetus has a health problem that would mean it likely wouldn't survive outside the womb. (Savransky, 3/20)

The Associated Press: Idaho Joins Other Red States With 'Abortion Reversal' Law
Idaho will become the latest conservative state to require women seeking abortions to be informed that the drug-induced procedures can be halted halfway, despite opposition from medical groups that say there is little evidence to support that claim. Gov. C.L. "Butch" Otter quietly signed the proposal into law Tuesday along with nearly 50 other measures. The law, which will go into effect July 1, is the latest move by Republican-dominant states that are testing the government's legal ability to restrict a woman's right to terminate a pregnancy. (Kruesi, 3/20)

Des Moines Register: 'Fetal-Heartbeat' Abortion Bill Hearing Draws Scores To Statehouse
A proposal to outlaw almost all abortions in Iowa drew a throng of residents to the Statehouse on Tuesday evening in a hearing that tipped back and forth between the two passionate sides of the argument. Legislators heard from doctors who portrayed abortion as an important health-care option and doctors who portrayed it as murder. They heard from pastors who see abortion as the taking of a sacred life and from pastors who see it as a decision to be made according to a woman's beliefs. And they heard from women who said abortions ruined their lives and women who said abortions saved their lives. (Leys, 3/20)

Meanwhile, emails reveal what happened behind the scenes when grants were cut for a teen pregnancy prevention program —

The Hill: Political Appointees Led Cancelation Of Teen Pregnancy Prevention Program
Internal emails and memos reveal that political appointees at the Department of Health and Human Services (HHS) went against career officials' objections by deciding to cut short grants aimed at preventing teen pregnancy. Documents released under a Freedom of Information Act (FOIA) request indicate that three political appointees directed the changes to the Teen Pregnancy Prevention (TPP) program: Valerie Huber, who prior to joining HHS headed a national abstinence education advocacy group; Teresa Manning, a former anti-abortion rights lobbyist who has since left HHS; and

Steven Valentine, who previously worked for Rep. Chris Smith (R-N.J.), chairman of the Congressional Pro-Life Caucus. (Hellmann, 3/20)

And, despite his anti-abortion rights stance this Illinois Democrat won his primary —

The Washington Post: Rep. Lipinski Of Illinois Narrowly Wins Democratic Primary
Rep. Dan Lipinski of Illinois, one of the most conservative Democrats in Congress, narrowly won a primary Tuesday over a progressive newcomer who argued the congressman's views no longer reflect the Chicago-area district he has represented for seven terms. Marie Newman, who was little-known when she decided to challenge Lipinski for the seat he inherited from his father, had backing from progressive groups as well as Sen. Bernie Sanders, who won Illinois' 3rd Congressional District by 9 points over Hillary Clinton in the 2016 Democratic primary. ... She campaigned as the "true Democrat," blasting Lipinski for opposing abortion and voting against same-sex marriage and President Barack Obama's signature health care overhaul. (Burnett, 3/21)

PUBLIC HEALTH AND EDUCATION

17. FDA Resumes Focus On Regulating Menthol, Tobacco Flavors That Attract Young People

More than 50 percent of underage smokers reported using menthols, compared with only 36 percent of adult smokers. "The FDA must use the full force of its authority in a scientific and transparent manner to address flavoring issues, especially in regard to youth," said Chris Hansen of the American Cancer Society.

The Associated Press: US Regulators Renew Scrutiny Of Menthol, Tobacco Flavors
Federal health officials are taking a closer look at flavors in tobacco products that appeal to young people, particularly menthol-flavored cigarettes, which have escaped regulation despite nearly a decade of government scrutiny. The Food and Drug Administration issued a call Tuesday for more information about flavored cigars and electronic cigarettes, which currently have no flavor restrictions. (3/20)

The Hill: FDA Takes First Step In Regulating Flavors In Tobacco Products
"In the spirit of our commitment to preventing kids from using tobacco, we are taking a closer look at flavors in tobacco products to better understand their level of impact on

youth initiation," FDA Commissioner Scott Gottlieb said in a press release. (Roubein, 3/20)

STATE WATCH

18. Viral Video Of Patient In Gown Found On Street Leads To Baltimore Hospital Being Cited By Federal Regulators

The problem of hospitals "patient dumping" was spotlighted when the video showing a disoriented woman in just a hospital gown spread on social media. The University of Maryland Medical Center Midtown was cited for violating patient rights and safety rules.

The Baltimore Sun: Federal Regulators Say University Of Maryland Hospital Violated Rules In Patient Dumping Case
Federal regulators have cited the University of Maryland Medical Center Midtown for violating patient rights and several patient safety and hospital management regulations related to a January incident in which a woman was discharged from its emergency room in just a hospital gown. The woman, who has been identified only as Rebecca, was found outside the hospital in frigid temperatures by a local psychotherapist who ran into her after leaving work. He called an ambulance and she was taken back to the emergency room and eventually put in a cab to a homeless shelter. (McDaniels, 3/20)

The Washington Post: Baltimore Hospital Faulted By Regulator After Mentally Ill, Half-Naked Woman Pushed Into Cold
In a widely viewed video circulated on social media in January, a mentally ill woman identified by her family only as Rebecca was removed from the University of Maryland Medical Center by security guards. "So wait, y'all just going to leave this lady out here with no clothes on?" Imamu Baraka, who filmed the incident, asked the guards. Rebecca's face appeared bloody, and she moaned: "Please help me!" (Moyer, 3/20)

19. Kansas Lawmakers Try To Tackle Issue Of Children's Deaths While In State Custody

The state lawmakers are considering creating a watchdog based outside the state's child welfare agency, but with access to inside information, as well as taking other steps to address failures in the system.

KCUR: Legislators Pushing Kansas Child Welfare Agency To Tell More About Fatal Cases
Kansas Lawmakers moved Tuesday to make a bill to release information about the deaths of children in state custody more transparent. In response to several high-profile cases where a child who had been brought to the attention of the Department for Children and Families and later died, the bill requires the agency to release information about kids who die as a result of abuse or neglect. (Fox, 3/20)

KCUR: Kansas Legislators Weigh Creating Independent Child Welfare Watchdog
Kansas lawmakers are considering creating a watchdog based outside the state's child welfare agency, but with access to inside information. A bill to create a child advocate to review the Department for Children and Families comes after years of horror stories of abused children who ended up injured, missing or dead. (Fox, 3/20)

KCUR: Bill Would Let Faith-Based Agencies Apply Beliefs In Child Placement, Even To Exclude LGBT Parents
A bill before Kansas lawmakers says faith-based child agencies should not be required to place children in families if it conflicts with the religious values of the organization. The private groups currently can choose not to serve some people, such as single parents or same-sex couples. (Koranda, 3/20)

20. State Highlights: Over-Sedation Crisis In Kan. Nursing Homes Won't Be Fixed By Proposed Regulations, Groups Say; Lead Poisonings Still Higher In Cleveland Children

Media outlets report on news from Kansas, Ohio, Massachusetts, California, Connecticut, Ohio, Virginia and Georgia.

Kansas City Star: Kansas Anti-Psychotic Use Informed Consent Bill Gets Hearing
Kansas ranks as one of the worst states for the overuse of anti-psychotic drugs to sedate nursing home residents. But new regulations on the practice faced stiff

opposition during a hearing Tuesday in Topeka from groups that represent the state's doctors, hospitals and skilled nursing facilities. (Ryan and Marso, 3/20)

Cleveland Plain Dealer: Cleveland Kids Still Poisoned By Lead At 4 Times The National Average, State Data Shows
About 12 percent of city children under 6 who were screened for lead in 2016 and 2017 had a level of the toxin in their blood that required action, according to new data released by the Ohio Department of Health. The numbers of children poisoned in Cleveland and Cuyahoga County have remained mostly stable for several years following more than a decade of steep decline. (Dissell and Zeltner, 3/21)

Boston Globe: Nurses Union, Hospitals Battle Over Ballot Question Setting Patient Limits
A ballot initiative backed by the Massachusetts Nurses Association would set strict limits on the number of patients assigned to a nurse at one time, for all hospital units in the state. Union nurses say they are often overburdened, leaving them unable to give the best possible care and increasing the risk of patient falls, infections, and other complications. (Dayal McCluskey, 3/20)

Sacramento Bee: 2 Sacramento Hospital Groups Reach Settlements With Labor Unions
Both Dignity Health and Kaiser Permanente announced Monday that they had reached major contract agreements with labor unions representing thousands of employees at the two companies. The roughly 15,000 members of SEIU-United Healthcare Workers West concluded voting Friday, ratifying a five-year contract with Dignity that will increase pay by 13 percent over the term of the deal. (Anderson, 3/20)

The CT Mirror: Home-Care Contract Wins Bipartisan Support Ahead Of Vote
A bipartisan coalition of Connecticut lawmakers and the governor voiced support Tuesday for a proposed contract that will raise wages, provide workers' compensation and increase training programs for about 8,500 home-care workers. The House and Senate are scheduled to vote on the contract Wednesday, which would increase wages to $16.25 per hour by 2020. (Rigg, 3/20)

Chicago Tribune: Tempus, Chicago Company Using Data To Help Personalize Cancer Care, Gets $80M In New Funding

Tempus, a Chicago-based technology company that uses data to help personalize cancer care and improve its efficiency, said Tuesday it has received $80 million in funding from a group of new and existing investors. The company, led by Groupon co-founder Eric Lefkofsky, has received $210 million in investment since it was founded in 2015. The latest fundraising round puts Tempus' value at approximately $1.1 billion, according to a source close to the deal. A valuation of more than $1 billion gives the company "unicorn" status, a label few Chicago startups can claim. (Bomkamp, 3/20)

Modern Healthcare: St. Joseph Health Creating Regional Board For Northern California Hospitals
St. Joseph Health will soon institute a regional board to oversee key moves like capital planning, joint ventures and hiring and firing of chief executives for four Northern California hospitals that currently make such decisions in-house. The four hospitals—Santa Rosa (Calif.) Memorial Hospital, Queen of the Valley Medical Center in Napa, St. Joseph Hospital in Eureka and Redwood Memorial Hospital in Fortuna—each will continue to operate community boards, but they will not have fiduciary oversight. St. Joseph Health teamed up with Providence Health & Services to form the 50-hospital Providence St. Joseph Health in 2016. (Bannow, 3/20)

Sacramento Bee: Sutter And Insurance Giant Aetna Hire Industry Veteran To Lead Joint Venture
After a nationwide search, Sutter Health and Aetna announced Tuesday that they have selected health industry veteran Steve Wigginton to lead a health plan the two companies founded in June 2017. (Anderson, 3/20)

The Roanoke Times: Report Finds Death Rates Rise For White, Middle-Class Virginians
Life expectancy rates have been dropping for several years in the U.S., a phenomenon not seen in other industrialized nations. Researchers looking at the trends have found that death rates for younger, white Americans are rising nationwide and have been studying contributing factors. (Rife, 3/20)

Georgia Health News: Alzheimer's Deaths In Georgia Show Major Increase
Georgia's death toll from Alzheimer's disease has increased by 201 percent since the year 2000, and now exceeds 3,700 people annually. That jump was included in new

statistics on the disease released Tuesday by the Alzheimer's Association at a state Capitol news conference. (Miller, 3/20)

Cleveland Plain Dealer: Akron City Council Hears Health Experts As It Mulls Raising The Legal Age To Buy Tobacco To 21
Ohio has the 8th highest smoking rate in the U.S., and while numbers of smokers in other states are declining, in the Buckeye State they're on the rise. Those statistics were delivered to Akron City Council's Health & Social Service committee on Monday by Cleveland Clinic Akron General's chief cardiologist Robert Schweikert. (Conn, 3/20)

Richmond Times-Dispatch: Altria Subsidiary Asks FDA To Review Smokeless Tobacco Brand As A "Modified Risk" Product
Tobacco giant Altria Group Inc. has submitted an application to the U.S. Food and Drug Administration to market one of its smokeless tobacco products as potentially less risky to health. Henrico County-based Altria said Tuesday that its U.S. Smokeless Tobacco Co. subsidiary submitted the "modified risk" application to the FDA for its Copenhagen Snuff Fine Cut moist smokeless tobacco product. (Reid Blackwell, 3/20)

Georgia Health News: Legislative Twists: A Standoff On Nursing Bill, And A Boost For Sports Medicine Center
A wild day in health care at the state Capitol on Tuesday began with a morning legislative hearing on something Democrats have sought for years: Medicaid expansion. No vote was taken on the expansion legislation, which was presented to the House Appropriations subcommittee on health. (Miller, 3/20)

Sacramento Bee: Homeless Patients Bused From Las Vegas Hospital Now Part Of Lawsuit
Mentally ill people who were cast out of a Las Vegas psychiatric hospital and issued Greyhound bus tickets to cities across the country without proper consent, care or planning soon will have their day in court. A Nevada court has ruled that James Flavy Coy Brown, whose 2013 bus trip took him to Sacramento, and potentially hundreds of others who had similar experiences, may as a group pursue damages against Rawson-Neal Psychiatric Hospital in Las Vegas, Southern Nevada Adult Mental Health Services, which oversees the hospital, and various treatment professionals. (Hubert, 3/21)

21. Dozens Of Hospitals Want In On New Nonprofit Generic Drug Company Aiming To Curb High Costs

News outlets report on stories related to pharmaceutical pricing.

Politico: Nonprofit Generic Drug Venture Could Include Third Of Hospital Market
A nonprofit generic drug company led by some well-known U.S. hospital systems and the Department of Veterans Affairs is trying to expand the market for inexpensive medicines — fast. The nonprofit aims to fulfill two needs. It wants to produce generic drugs that are in short supply. And it's trying to create more competition for pricey, older off-patent drugs so that they become more affordable. (Karlin-Smith, 3/19)

Stat: Are Consumers Overpaying At The Pharmacy Counter?
Americans may be overpaying for their prescription medicines nearly one-quarter of the time, although the average amount was relatively modest — less than $8. And there were more overpayments involving generic drugs than brand-name medicines, according to a new analysis. Of about 9.5 million prescription insurance claims filed from January to June 2013, 2.2 million involved overpayments, and these totaled $135 million, or $10.51 per person, according to the analysis that was published in the Journal of the American Medical Association. And about 17 percent of the claims resulted in an overpayment exceeding $10. (Silverman, 3/16)

Boston Globe: Everyone Wants To Kill Generic Drug Loophole -Except Drug Makers And Some GOP Leaders
In recent years brand-name drug makers realized they could block generic competition by refusing to sell samples of their products to companies that wanted to make the lower-cost copies. All they had to do was cite safety rules that restrict sales of certain drugs with dangerous side effects. (Rowland, 3/19)

Stat: HHS Is Urged To Investigate A Gilead Hepatitis C Patent For Failing To Disclose Federal Funding
An advocacy group asked the Department of Health and Human Services to investigate whether a key hepatitis C patent held by Gilead Sciences (GILD) failed to disclose federal funding for grants that were used to develop the blockbuster Sovaldi treatment.

In making its request, the advocacy group cited a federal database purportedly showing a patent awarded to Pharmasset, which developed Sovaldi, had received funding from the National Institutes of Health for four grants. The grants were provided between 2003 and 2006, and the patent was issued in June 2011, a few months before Gilead bought Pharmasset for $11 billion. (Silverman, 3/15)

Stat: NIH Urged To Probe Aegerion Patents For Failing To Disclose Federal Funding
An advocacy group has asked the National Institutes of Health to investigate whether several patents held by Aegerion Pharmaceuticals failed to disclose federal funding for grants that were used to develop a pricey cholesterol treatment. In its request, the advocacy group cited a federal database showing six patents were awarded to the University of Pennsylvania, where an academic researcher used NIH grants to develop a drug called Juxtapid, which was later licensed to Aegerion Pharmaceuticals. The school has received more than $68 million in grants for research led by Dr. Daniel Rader, who chairs the genetics department at the Perelman School of Medicine, and at least $293,000 pertained to his work on Juxtapid, according to Knowledge Ecology International, the advocacy group. (Silverman, 3/20)

Bloomberg: Drug Distributors Sink On Pricing, Opioid Litigation Concerns
Investors are running for the exit in anticipation of federal action against drug companies blamed for the opioid crisis. Drug distributors including Cardinal Health, AmerisourceBergen and McKesson extended losses for a second day as President Donald Trump pledged to lower drug prices "very substantially in the not-so-distant future." He said the Justice Department is considering "major" federal litigation against the companies involved in the crisis. (Darie, 3/20)

Stat: Massachusetts Court Says Merck — And Pharma — May Be Sued Over Generic Warnings, Sometimes
In a setback to the pharmaceutical industry, the Massachusetts Supreme Judicial Court decided that consumers who claim harm from a generic medicine can sue brand-name drug makers for intentionally failing to update warnings that generic companies are obligated to place on product labeling. The ruling came in a lawsuit filed by a man who charged that he suffered side effects, notably sexual dysfunction, after taking a generic version of Proscar, a Merck (MRK) drug used to treat enlarged prostates. And he maintained that two years before he took the generic, which was sold by Mylan (MYL),

Merck changed Proscar labeling in other countries to warn about persistent erectile dysfunction, but had not done so in the U.S. (Silverman, 3/19)

Stat: Tens Of Millions Of People Continue To Lack Access To Hepatitis C Medicines
Nearly 71 million people around the world are infected with hepatitis C but access to effective medicines remains elusive and, as a result, only a fraction were able to obtain treatment, according to a new report from the World Health Organization. Globally, the number of people who initiated treatment rose between 2015 and 2016, from approximately 1 million people to 1.5 million people. And so, the WHO issued a rallying cry to find ways to provide medicines to the tens of millions of people who are going untreated. (Silverman, 3/15)

The Wall Street Journal: CVS To Hire Former Eli Lilly CFO To Run Pharmacy Benefit Business
CVS Health Corp. tapped a former Eli Lilly & Co. finance chief to run its pharmacy benefit business as the drugstore giant works to complete an acquisition of insurer Aetna Inc. Derica Rice, a longtime Eli Lilly chief financial officer, is set to take over at CVS Caremark on March 30, according to an internal CVS memo reviewed by The Wall Street Journal. Mr. Rice will succeed Jonathan Roberts, who was promoted last year to the role of chief operating officer at CVS Health. (Terlep, 3/20)

Stat: Drug Makers Are Paying Fewer And Fewer Fines For Their Bad Behavior
Nearly a decade ago, numerous drug makers paid huge fines for various fraudulent practices, but a falloff that began a few years ago has since accelerated dramatically, according to an analysis by Public Citizen, the consumer advocacy group. Pharmaceutical companies paid roughly $2.9 billion to settle 38 cases involving federal and state civil and criminal charges in 2016 and 2017. This was quite comparable to the $2.9 billion paid for 39 settlements covering the previous two-year period, but much less than the 117 settlements totaling $9.8 billion during 2012 and 2013. (Silverman, 3/14)

Stat: The Anxious Launch Of Luxturna, A Gene Therapy With A Record Sticker Price
The treatment, developed after decades of research, is called Luxturna, and it is sometimes referred to as the first "true" gene therapy to be approved by the Food and Drug Administration. Cancer treatments such as Kymriah and Yescarta are also sometimes described as a kind of gene therapy, but they involve removing a patient's

cells, genetically modifying them, and sending them back into the body to fight the disease. With Luxturna, a doctor injects a virus underneath the retina, where it delivers a healthy, lab-grown copy of the RPE65 gene into the cells. If the therapy works for these patients, it could help restore some of the images they have been missing. (Boodman, 3/21)

Chicago Tribune: Daughter's Epilepsy Controlled By Drug, Then Insurer Stopped Covering It. Bill Would Ban Such Midyear Changes.
It took four years for Joanne Guthrie-Gard to find the right seizure medication for her daughter, whose epilepsy, during the worst of it, caused her to have 20 seizures a week. ...The family's insurance plan covered the new drug. Until it didn't. About four months in, Gard was told to go back to the original drug or pay out of pocket for the extended-release version, which at the time cost about $10,000 for a three-month period. (Elejalde-Ruiz, 3/14)

Minnesota Public Radio: Bill Could Help Reduce Cases Of Minnesotans Overpaying For Prescription Drugs
Insurance companies negotiate discounts for their members with pharmacy chains, just as they do with health care providers. Sometimes, though, a pharmacy's standard price is less than the insurer's negotiated rate. ... A bill up for a hearing in front of a Minnesota Senate committee would ban disclosure prohibitions that can stand in the way of pharmacists laying out best price options for their customers. (Zdechlik, 3/19)

Kansas City Star: Low-Income Seniors Struggle For Prescriptions Without MORx
Prunty is one of about 63,000 Missouri seniors who lost their MORx coverage, which helped people who made too much money to qualify for Medicaid but not enough to afford their medication. Without that coverage, some seniors may end up stopping their medications or spreading out the dosage, said James Stowe, director of aging and adult services for the Mid-America Regional Council. (Kite, 3/18)

22. Perspectives: Drugmakers Are Unfairly Restricting Competition, And Congress Needs To Act

Read recent commentaries about drug-cost issues.

Stat: It's Time To Empower Generic Drug Makers To Bring Down Prices
In Vermont, Iowa, and every other state across the country, people are fed up with the high cost of prescription drugs. Prices continue to skyrocket as companies making brand-name drugs restrict competition by refusing to share samples of their drugs with companies aiming to make generic versions or refusing to negotiate a shared safety protocol. This is an abuse of government regulations that are intended to protect patients and ensure drug safety. (Patrick Leahy and Chuck Grassley, 3/16)

The Hill: Be Wary Of Canada's Drug Price Controls And Lack Of IP Protections
There is an ill-thought out war underway on brand-name drug prices and pharmaceutical intellectual property (IP). Washington can learn from Canada's mistakes. President Trump has asked CEOs of research-based pharmaceutical manufacturers to lower U.S. drug prices and increase jobs in America. Given the fact more is already spent on pharmaceutical R&D in the U.S. than anywhere else, this presents a serious challenge for U.S. and other global pharmaceutical companies. (Robert A. Freeman, 3/19)

Forbes: Strike The Right Regulatory Balance To Promote Generic Medicines And Future Innovation
Striking the right regulatory balance for pharmaceuticals is no easy task. On the one hand, policy should promote drug affordability by encouraging robust competition. On the other hand, policy should encourage future innovations by granting these drugs temporary market exclusivity. While these goals appear contradictory, the federal government's drug approval process has reasonably balanced these competing interests for many years. This approval process is based on legislation passed in 1984 colloquially known as the Hatch-Waxman Act. (Wayne Winegarden, 3/14)

The Wall Street Journal: A GOP Right-To-Try Fumble
President Trump has never been accused of being a policy wonk, but now and then he fixates on a good idea, and one has been the "right to try" experimental drug therapies still seeking approval by the Food and Drug Administration. The question is why a GOP Congress is bungling this ostensible White House priority. (3/20)

Bloomberg: Alzheon IPO S-1: Beware Biotechs Bearing Alzheimer's Retreads
Perseverance can be admirable. But in biotechnology, it's often a mistake. Massachusetts biotech Alzheon Inc. filed an S-1 with the SEC on Friday ahead of a

planned IPO. It should arguably come with a warning label. The company plans to run a a new final-stage trial for a previously failed Alzheimer's drug, saying it benefited a subset of patients in an earlier trial. (Max Nisen, 3/19)

Forbes: Physicians And Patients Finally Avoiding Horizon's Expensive, Low-Value Pain Drugs Duexis And Vimovo
Nary a day goes by without a story on the cost of drugs. The discussion tends to blur a variety of different issues: the cost of breakthrough cures of diseases like childhood leukemia or hepatitis C, unconscionable price increases of generic drugs, and multiple price increases of patented branded drugs in a given year. These issues and others merit discussion as people try to rein in healthcare costs. (John LaMattina, 3/15)

EDITORIALS AND OPINIONS

23. Viewpoints: Can Congress Make A Deal, Prop Up Obamacare?; Trump's Speech On Opioid Plans Hit New Lows

Editorial pages highlight these health topics and others.

The Washington Post: Obamacare's Fate Hinges On A Bipartisan Vote That May Never Come
Congress mus vote by the end of the week to fund the government, passing a massive "omnibus" spending bill that may (believe it or not) represent the last time this year lawmakers make significant policy changes. In other words, once the omnibus bill clears Congress, there is little chance lawmakers will approve fixes to Obamacare before the 2019 enrollment season begins. (3/20)

Bloomberg: Trump Talks Tough On Opioids
When it comes to the opioid crisis, President Donald Trump likes to sound tough, including multiple uses of the word itself. "If we don't get tough on the drug dealers, we're wasting our time," he said Monday. "And that toughness includes the death penalty. "Trump's speech in New Hampshire, part of the administration's rollout of its strategy for fighting the crisis, elevated talk over action. By emphasizing capital punishment, Trump has squandered another opportunity to lead a concerted, effective fight against opioid addiction and overdose. (3/20)

The Wall Street Journal: Abortion Over ObamaCare
One reality of 2018 is that both parties are in a contest for who can isolate more voters with radical positions that don't represent most Americans. The Democrats may be winning this one. Congress this week is debating a deal that would prop up ObamaCare for three years with tens of billions of dollars. Yet Democrats have revolted because the deal includes the 1970s Hyde Amendment, which bans federal funds from subsidizing abortion. (3/20)

The New York Times: Trump's Bluster On The Opioid Epidemic
President Trump has declared that his administration is getting serious about the opioid epidemic several times since taking office. But he has repeatedly failed to offer a substantive plan — and he has floated at least a few truly absurd ideas. He did it again this week. Mr. Trump gave a rambling speech on opioids on Monday in which he offered few details about how he would increase access to substance abuse treatment and prevention to help the millions of Americans suffering from this disease. Some 64,000 people in the United States died of drug overdoses in 2016, including 481 in New Hampshire, one of the hardest hit states in the country, where Mr. Trump gave his speech. (3/20)

The Washington Post: Killing Drug Dealers Won't Stop The Opioid Epidemic
Whenever some crime becomes prominent in the public eye, some politician inevitably promises to fix it by getting really tough on criminals. No more of this namby-pamby mollycoddling! This time, we're going to make it so miserable to be a criminal that no one will dare. (Megan McArdle, 3/20)

Los Angeles Times: Trump Wants A New War On Drugs
President Trump's opioid response plan might have multiple prongs, but when he unveiled it Monday, he clearly was most interested in the prong that gets "very tough" on drug dealers. We know this because he said so approximately 5,000 times during a speech announcing the new plan in New Hampshire, a state chosen as the backdrop because it is one of those hardest hit by opioid addiction and overdose deaths. (3/20)

Axios: Why Health Care Probably Didn't Decide The Pennsylvania Election
The buzz is that health care played a leading role in Conor Lamb's upset win in last week's special House election in Pennsylvania. But in reality, we can't say that health

care was a decisive factor in Lamb's win, at least not based on the one poll that is being used as a basis for that claim. (Drew Altman, 3/21)

Bloomberg: Gun Confiscation: NRA Feels It Must Voice Support For 'Red Flag' Laws
Students and activists are preparing what will almost certainly be the nation's largest mass demonstration against gun violence -- and the shoddy laws that fuel it -- on March 24. The March for Our Lives is the bitter fruit of one school massacre too many, the Feb. 14 mass shooting at Marjory Stoneman Douglas High School in Parkland, Florida. Waves of outrage follow every gun massacre. But this wave has been effectively channeled, with teen survivors proving canny leaders in shaping what could become a generational cause.The NRA is acutely aware of the precariousness of the moment. (Francis Wilkinson, 3/20)

The New York Times: Fighting Death By Gunshot
Kenji Inaba is a trauma surgeon at Los Angeles County General Hospital and director of the surgical intensive care unit. He's also a sworn reserve police officer, part of a two-man patrol in the Rampart Division of the Los Angeles Police Department. Between policing and doing emergency surgery, he gets a lot of exposure to gunshot wounds, both entry and exit — how people get shot, and how they get better. (Tina Rosenberg, 3/20)

Charlotte Observer: Adults Trying To Ignore Students' Message After School Shootings
Boomers knock the kids to cover for themselves because the kids, in their call for action and the attention it's getting, are knocking them. It's Baby Boomers and other like-sounding adults, typically of a particular political persuasion, who can vote, can choose school officials, and can change laws — but have failed miserably on the school shootings front. They knock not merely the points the students are making but the kids themselves, in sweeping, demeaning ways. If they can invalidate the students, the adults don't even have to consider what the kids are saying. (Keith Larson, 3/20)

St. Louis Post Dispatch: Grown-Ups Have Failed Our Kids On Gun Legislation
How did my legislative colleagues react to the school shooting? Rep. Chuck Basye, Second Amendment Preservation Committee chair, invited the Missouri House on a tour next week of CMMG Inc., a leading manufacturer of AR-15 rifles, conversion kits and accessories, in Boonville, Mo. The gun of choice in mass shootings? An AR-15. As

Emma Gonzalez, a Stoneman Douglas High School senior and survivor, said in her national rally speech that went viral, I say BS. (Stacey Newman, 3/20)

The Wall Street Journal: Stephen Hawking Is Dead, Not 'Free'
Does my wheelchair feel like a prison? Do I ever wish I weren't disabled? Would I choose to become able-bodied if I could? Those are a few of the things people have asked upon meeting me. My answer is always the same: a strong and unequivocal "no." I've never fully understood the mentality behind the questions, much less the shocked reactions to my replies. And then I saw the response to Stephen Hawking's death last week, when people sighed with relief that one of the most brilliant minds of our generation was finally "free of any physical constraints," as the actress Gal Gadot tweeted. One meme depicted an empty wheelchair in the foreground, with a silhouette of Hawking standing amid the stars. (Melissa Blake, 3/20)

The Wall Street Journal: Why Your Doctor's Computer Is So Clunky
The Trump administration this month announced its own effort to update the Electronic Health Record systems, which disrupt the doctor-patient relationship. The government could do even more good by deregulating EHRs, establishing a free market for user-friendly products. Perhaps Amazon, through its partnership with JP Morgan Chase and Berkshire Hathaway , could eventually do for medicine what it's done for retail. (Marion Mass and Kenneth A. Fisher, 3/20)

Bloomberg: Stanford Diet Study Casts Doubt On Calorie Counting
The problem is that we're not in charge of running our bodies. Even with modern food labeling and calorie-counting apps, forces beyond our conscious control keep fiddling with how many calories we burn each day, and how hungry we feel. The longstanding illusion of control has implications for America's health care policy, since obesity is tied to the major killers -- heart disease; diabetes; and, to a lesser extent, cancer and Alzheimer's disease. Many Americans wrongly think that the two-thirds of their fellow citizens who are overweight or obese are to blame for eating too many calories. (Faye Flam, 3/20)

Des Moines Register: Iowa Child Death Another Reminder Of Need For Medical Error Reporting
On a summer morning in 2016, Scott and Sandy Van Veldhuizen of Oskaloosa woke up early to drive their son Reuben to West Lakes Surgery Center in Clive. The 12-year-

old was to undergo a tonsillectomy and adenoidectomy, relatively routine procedures performed on thousands of children each year. "Go get 'em, bud," were the last words Scott said to his son before he was wheeled away. (3/20)

Alexander, Steven

From: Parsons, Jason
Sent: Thursday, May 11, 2017 11:50 AM
To: House_All
Subject: Open Enrollment 2017!
Attachments: 2017-2018 Pathways Open Enrollment.pdf; Open Enrollment 2017.ppsx

Importance: High

Open Enrollment 2017 will take place May 15 through May 26, 2017. All changes made during open enrollment will take effect July 1, 2017 and remain effective through June 20, 2018.

Please read the information listed below, along with the attached power point, as they outline changes for the upcoming benefit year!

Medical & Pharmacy

- Medical deductibles will be $250 for single and $500 for family in-network, and $500 for single and $1,000 for family out-of-network.
- The copay for an emergency room visit will be $100, which is waived if patient is admitted as inpatient.
- The copays for urgent care will be $30 for in-network and $35 for out-of-network.
- The copay for specialist visits will be $25 for in-network.
- The out-of-pocket maximums for pharmacy benefits will be $2,500 for single and $5,000 for family.

Take Charge! Live Well!

- Employees and spouses enrolled in the State of Ohio medical plan can earn up to $350 each again this year by taking the required actions to improve your health. However, some new criteria have been implemented to receive your reward.

Healthways

- Beginning July 1, 2017, due to new federal regulations, Healthways, the wellness program's third-party administrator, will require either written or online approval to access the program via Well-Being Connect®, Healthways' online portal for State of Ohio employees and spouses. Personal information on the Healthways portal is protected and confidential. Healthways does not share information or use information against the terms and conditions of the contract with the State of Ohio.

Below is the link to the DAS website for open enrollment:

http://www.das.ohio.gov/OpenEnrollment

IF YOU DO NOT HAVE A CHANGE IN STATUS OR DEPENDENTS, YOU DO NOT NEED TO DO ANYTHING DURING OPEN ENROLLMENT.

If you prefer to review a hard copy of the Pathways to Open Enrollment, there are copies available in the 12th floor administrative office. Feel free to contact me regarding any questions or concerns with the 2017 Open Enrollment.

Jason Parsons
Payroll & Benefits Officer
Ohio House of Representatives
(614) 466-2114


OHIO DEPARTMENT OF ADMINISTRATIVE SERVICES AND THE JOINT HEALTH CARE COMMITTEE
MyBenefits
FOR STATE OF OHIO EMPLOYEES
MEDICAL
PRESCRIPTION DRUG
BEHAVIORAL HEALTH
WELLNESS
DENTAL & VISION
LIFE INSURANCE
2017 OPEN ENROLLMENT
MAY 15-26
OhioDAS
SERVICE · SUPPORT · SOLUTIONS
DEPARTMENT OF ADMINISTRATIVE SERVICES

2017 Benefits Overview

Welcome to the 2017 Open Enrollment edition of MyBenefits magazine. The purpose of this edition is to inform you and your family about the State of Ohio's employee health care benefits available this coming benefit year, which begins July 1, 2017.

Eligible employees can elect to enroll or disenroll themselves and/or their dependents in medical, dental, vision and supplemental life insurance coverage during the Open Enrollment period, which is being held Monday, May 15 through Friday, May 26.

If you already are enrolled in benefits, please review your Benefits Summary by logging into *myOhio.gov* and clicking the myBenefits button to access the benefits information for you as well as your dependents, if applicable. Ensure your dependents still meet the eligibility requirements by visiting *das.ohio.gov/EligibilityRequirements*. If you do not have any changes to your coverage, no additional action is required.

If you wish to waive your current health coverage, you will need to do so during Open Enrollment.

Important Changes for the Upcoming Benefit Year

- Medical deductibles will be $250 for single and $500 for family in-network, and $500 for single and $1,000 for family out-of-network.
- The copay for an emergency room visit will be $100, which is waived if patient is admitted as inpatient.
- The copays for urgent care will be $30 for in-network and $35 for out-of-network.
- The copay for specialist visits will be $25 for in-network.
- The out-of-pocket maximums for pharmacy benefits will be $2,500 for single and $5,000 for family.
- ***Take Charge! Live Well!*** – Employees and spouses enrolled in the State of Ohio medical plan can earn up to $350 each again this year by taking the required actions to improve your health. However, some new criteria have been implemented to receive your reward. Please see the Wellness Rewards chart on Page 13.
- **Healthways** – Beginning July 1, 2017, due to new federal regulations, Healthways, the wellness program's third-party administrator, will require either written or online approval to access the program via Well-Being Connect®, Healthways' online portal for State of Ohio employees and spouses. Personal information on the Healthways portal is protected and confidential. Healthways does not share information or use information against the terms and conditions of the contract with the State of Ohio.

  The Well-Being Connect portal for employees and spouses has been redesigned for a fresh, new look and a better user experience. Healthways will be performing updates from July 1 through July 17. During this time, Well-Being Connect will not be accessible.

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MyBenefits

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SAVE THE DATES

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- Open Enrollment ends May 26

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- Flexible Spending Accounts Open Enrollment ends Oct. 27

December
- Use your remaining Flexible Spending Accounts money by Dec. 31

2018

January
- New Flexible Spending Accounts plan year begins Jan. 1

February
- National Wear Red Day is Feb. 3

March
- 2017 Flexible Spending Accounts claims deadline is March 31

Benefits Eligibility

All eligible employees who currently are not enrolled or who need to make changes to medical, dental, vision or supplemental life insurance for themselves or their dependents can only do so during Open Enrollment, held from Monday, May 15 through Friday, May 26.

All choices made during Open Enrollment will become effective July 1, which begins the new benefit year. You will not have another opportunity to enroll yourself or eligible dependents for benefits or make changes to your elections until the next Annual Open Enrollment unless you experience a change in status/qualifying event, such as marriage, divorce, or the birth or adoption of a child.

For more information about qualifying events:

1. Go to *das.ohio.gov/benefits*;
2. Click on the link for the **Change in Status/Qualifying Events Matrix** along the right navigation pane.

ELIGIBILITY FOR BENEFITS: EMPLOYEES

- Medical – All permanent state employees are eligible to enroll in medical coverage (which includes prescription drug, behavioral health and wellness benefits) during Open Enrollment. Changes made during Open Enrollment are effective July 1. For more information about the eligibility of non-permanent employees pursuant to the Patient Protection and Affordable Care Act, please see *das.ohio.gov/EligibilityRequirements*.
- Dental and Vision – Permanent exempt and union-represented employees are eligible to enroll in dental and vision coverage effective the first day of the month after completing one full year of continuous state service or thereafter during Open Enrollment.
- Basic Life – Permanent exempt and union-represented employees are eligible for basic life coverage after completing one full year of continuous state service. Enrollment is automatic. The exempt employees' basic life insurance benefit is provided through Minnesota Life, a Securian company.
- Supplemental Life – Permanent exempt and union-represented employees are eligible for supplemental life coverage on their date of hire and have 90 days to enroll.*Permanent exempt and union-represented employees also may enroll or make changes during Open Enrollment. The exempt employees' supplemental life insurance benefit is provided through Minnesota Life.

*Certain new enrollments or increases are subject to evidence of insurability and may delay the effective date of coverage.

ELIGIBILITY FOR BENEFITS: DEPENDENTS

- Medical – Dependents are eligible for medical coverage up to the age of 26. Coverage may be continued if the dependent qualifies as a disabled dependent or elects coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).
- Dental and Vision – Dependents are eligible for dental and vision coverage up to age 18 without student status verification. Dependents between the ages of 19 and 23 are eligible for continued coverage as long as they maintain their student status. Student coverage is not automatic; employees are required to submit proof of eligibility within 31 days of the qualifying event. To initiate or continue coverage for your dependent, the employee is required to complete and return an "Affidavit of Student Status" form, accessed at *das.ohio.gov/forms* in the "Eligibility" section. In addition, a "Current Enrollment Verification Certificate" from the National Student Clearinghouse, *studentclearinghouse.org*, or a letter or official transcript from the school registrar must be submitted with the Affidavit of Student Status. If the proof of eligibility is provided timely, the dependent may continue on the coverage until he/she turns 23, when the dependent no longer meets the eligibility requirements, or the dependent is turning 23 and qualifies as a disabled dependent.

To view the detailed eligibility and enrollment requirements for dependents for medical, dental and vision, visit: *das.ohio.gov/EligibilityRequirements.*

Note: To ensure that dependent documentation is processed prior to July 1, it is recommended that employees submit all required eligibility documentation for dependents to your agency human resources office by June 1. The final deadline to submit all required documentation is July 31.

- Basic Life – Dependents are not eligible to enroll in exempt basic life coverage; however, they are permitted to be designated as an employee's beneficiary.
- Supplemental Life – Dependents are eligible for exempt supplemental life coverage. Supplemental life insurance provides up to $40,000 coverage for your spouse; $10,000 in coverage is available without evidence of insurability during Open Enrollment. If you apply for more than $10,000 in coverage for your spouse, Minnesota Life will mail a medical questionnaire to you that must be completed and returned.

  Supplemental life insurance in the amount of $7,000 for each child from birth until age 26 is available for a single monthly premium of .82 cents, regardless of how many children you cover.

  To elect supplemental life insurance for your dependents, you must be enrolled in supplemental life insurance for yourself.

To view the detailed eligibility and enrollment requirements for dependents for exempt basic and supplemental life insurance, visit: *das.ohio.gov/lifeinsurance.*

Eligibility for Benefits

DEPENDENT CATEGORY	MEDICAL	DENTAL	VISION	SUPPLEMENTAL LIFE
Children younger than age 23	Coverage available for eligible dependents[1]	Coverage available for eligible dependents[2]	Coverage available for eligible dependents[2]	Coverage available for eligible dependents
Children ages 23 - 25	Coverage available for eligible dependents[1]	No coverage available	No coverage available	Coverage available for eligible dependents

[1] View detailed eligibility and documentation requirements at: das.ohio.gov/EligibilityRequirements.

[2] Student verification is needed for dependents age 19 to age 23. View detailed eligibility and documentation requirements at: das.ohio.gov/EligibilityRequirements.

Note: When one of your enrolled dependents is, or becomes, ineligible for benefits coverage based on the state's definition of eligibility, it is your responsibility to contact your agency benefits specialist (or human resources office) immediately to remove them from your coverage. Your dependent may be eligible to continue their medical, dental and/or vision benefits through COBRA (continuation coverage) if you notify your agency benefits specialist (or human resources office) within 60 days after the qualifying event.

Enrollment or continuation of enrollment of an ineligible dependent may result in loss of benefits, disciplinary action and/or repayment of claims. If you fail to remove a dependent from coverage within 31 days of a qualifying event, you may be responsible for health care expenses incurred by the ineligible dependent.

Benefits Enrollment Instructions

To enroll, disenroll or make changes, please follow the steps below:

1. Review information about available benefits by carefully reading this Open Enrollment edition of *MyBenefits.* If you have questions, contact your agency benefits representative in your human resources office or the Ohio Department of Administrative Services' HR Customer Service desk at 800-409-1205, select option 2.
2. Enroll in medical, dental and vision coverage or make changes to your or your dependents' current coverage by going online to *myOhio.gov* or by obtaining a paper form.

A. Online

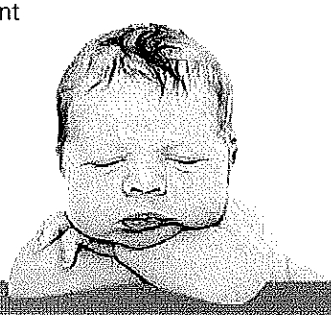
- Go to *myOhio.gov*. Enter your State of Ohio User ID and password. If you have forgotten your State of Ohio User ID or password, contact the OAKS Helpdesk by calling toll-free, 1-888-OHIO-OAK (1-888-644-6625), or in Columbus, 614-644-6625. Make sure to select option 1 when prompted;
- Click on **myBenefits** under Self Service Quick Access on the right side of the page;
- Your Benefits Summary page will open; review your current benefit information;
- Click on **Enroll in Benefits and make the necessary changes or updates**.
  - Submit your enrollment or changes. **All transactions must be completed, submitted and confirmed prior to 7 p.m. Friday, May 26. The system will not accept any entries after 7 p.m. Friday, May 26.** Make sure your online changes are correctly submitted by clicking the **SUBMIT** button on the last two pages of the process. At the end, you will receive a confirmation message that can be printed for your records.
    - For detailed instructions on how to enroll or disenroll online, go to: *das.ohio.gov/EnrollmentInstructions.*
    - Online Open Enrollment is available Monday, May 15 through Friday, May 26, 2017, as follows:

      Weekdays – All day except 7 to 9 p.m.
      Saturdays – All day except 4 to 6 p.m.
      Sundays – All day except 4 p.m. to midnight

B. Paper

- For medical coverage for all eligible employees and dental and vision coverage for exempt employees, obtain a paper State of Ohio Benefit Enrollment/Change Form (ADM 4717) on the Benefits Administration website at: *das.ohio.gov/HealthCareForms* or from your agency's human resources office.
- For all bargaining unit members, forms to change dental and vision coverage are available at *benefitstrust.org* Click the **Forms & Info** link.
- Submit your enrollment or changes by giving your completed and signed State of Ohio Benefit Enrollment/ Change Form (ADM4717) and/or the Union Benefits Trust Dental & Vision Enrollment Form to your agency's human resources office by **4 p.m. Friday, May 26.**

Following Open Enrollment, **all eligible employees will receive a confirmation letter in the mail.** This letter should arrive **in early June.** Please review this letter carefully to ensure your enrollment elections have been processed correctly.



IMPORTANT

If you are enrolling for the first time and/or adding new dependents during this Open Enrollment, you must provide the required eligibility documentation for your dependents. A listing of the required documentation can be found at *das.ohio.gov/EligibilityRequirements.*

Coverage will not be provided for dependents until the eligibility documents are received and approved. The final deadline to submit all required documentation is July 31.

You will not have another opportunity to enroll yourself or eligible dependents for benefits or make changes to your elections until the next Open Enrollment period unless you experience a change in status/qualifying event.

Medical Benefits

The State of Ohio contracts with Aetna, Anthem and Medical Mutual of Ohio to serve as the third-party administrators for the Ohio Med Preferred Provider Organization (PPO). The plan design is the same for all three third-party administrators. Under this plan, employees have access to both network and non-network providers.

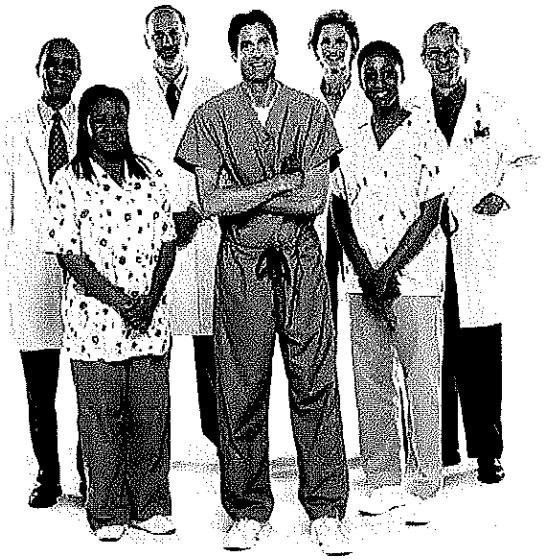
Aetna, Anthem and Medical Mutual each serve specific regions in Ohio based on home ZIP codes. You are assigned your third-party administrator based on the first three digits of your home ZIP code. Review the chart on the right that features the ZIP code breakdown by plan administrator. Employees whose home address is outside Ohio are automatically enrolled in Anthem.

For deduction information, see the charts on Page 9.

When you are enrolled in medical coverage, you automatically gain prescription drug, behavioral health and wellness benefits. Medical copayments, deductibles and co-insurance are combined with your behavioral health plan. If you receive medical services prior to meeting your deductible, you may need to pay for these services up to the deductible amount before the plan starts paying. (This does not apply to routine office visits for which you only pay an office visit copayment.)

TO OBTAIN INFORMATION FROM YOUR THIRD-PARTY ADMINISTRATOR:

If you would like to receive information about the plan, providers and ancillary programs from your assigned third-party administrator – Aetna, Anthem or Medical Mutual – refer to the Health and Other Benefits Contacts information on Page 17. You can visit your third-party administrator's website to download and print the information or call their customer service unit to request that it be mailed to you.



Medical Third-Party Administrator ZIP Code Chart

	3-Digit ZIP Code			
Aetna Plan/Network: Aetna Choice POS II (Open Access)	Columbus, Toledo			
	430	431	432	433
	434	435	436	448
	449			
Anthem Plan/Network: Blue Access (PPO)	3-Digit ZIP Code			
	Cincinnati, Dayton Southern Ohio, Springfield Youngstown, Out of State			
	437	438	439	444
	445	450	451	452
	453	454	455	456
	457	458		
Medical Mutual of Ohio Plan/Network: OhioMed	3-Digit ZIP Code			
	Akron, Cleveland			
	440	441	442	443
	446	447		

SAVE MONEY: USE BENEFITS WISELY

All of the State of Ohio's health plans are self-funded. This means that the cost of your benefits is funded by contributions from you and your agency. All claims are paid for from contributions – your third-party administrator does not pay for your claims. Rather, Aetna, Anthem and Medical Mutual review claims and process payments, and are paid an administrative fee. When the amount of paid claims is greater than the amount of contributions from employees and agencies, medical costs go up.

It is up to each of us to use our benefits wisely. We can all do our part by making wellness a priority in our lives, evaluating our options when we need care and avoiding unnecessary visits.

Take advantage of consumer tools provided by our medical third-party administrators that will enable you to shop and find lower costs for the services they provide (MRIs, labs, surgeries, etc.).

Ohio Med PPO

OUT-OF-POCKET COSTS	
Annual Deductible	$250 single, $500 family in-network; $500 single, $1,000 family (combined with behavioral health) out-of-network.
Your Copayments (Office Visits)	Primary care physician: $20 in-network, $30 out-of-network; Specialist: $25 in-network: $30 out-of-network.
Coinsurance	You pay 20%, plan pays 80% in-network; you pay 40%, plan pays 60%[1] out-of-network.
Your Out-of-Pocket Maximum [2]	$1,500 single, $3,000 family in-network; $3,000 single, $6,000 family[3] (combined with behavioral health) out-of-network.
BENEFIT/SERVICE	**COVERAGE LEVELS**
Chiropractic Care	▪ Covered at 80% in-network; 60% out-of-network. ▪ Unlimited visits (review required).
Diagnostic, X-Ray and Lab Services	▪ Covered at 80% in-network; 60% out-of-network.
Durable Medical Equipment	▪ Covered at 80% in-network; 60% out-of-network.
Emergency Room	▪ Covered at 80%; $100 copay, which is waived if patient is admitted as inpatient; 60% out-of-network for non-emergency.
Hearing Loss[5] (Accidental, Injury or Illness)	▪ Covered at 80% in-network; 60% out-of-network. ▪ Hearing aids, exams and follow-ups are included in coverage.
Home Health Care	▪ Covered at 80% in-network; 60% out-of-network; limit of 180 days.
Hospice Services	▪ Covered at 100% with no copay, time or dollar limitations for both in- and out-of-network.
Immunizations	▪ Most are covered at 100% in-network; 60% out-of-network.[4]
Infertility Testing	▪ Covered at 80% after applicable copay, for in-network; 60% after $30 copay out-of-network. ▪ Coverage includes testing only.
Inpatient and Outpatient Services	▪ Covered at 80% in-network; 60% out-of-network.
Maternity - Delivery	▪ Covered at 80% in-network; 60% out-of-network.
Maternity - Prenatal/ Postpartum Care	▪ Prenatal Care: Office visits covered at 100% when billed separately from delivery; tests/procedures covered at 80% in-network; 60% out-of-network. Postpartum Care: breast-feeding support and counseling (including lactation classes), and supplies (including breast pump rental) covered at 100%.
Physical, Occupational and Speech Therapy	▪ Covered at 80% in-network; 60% out-of-network. ▪ Unlimited visits (review required). ▪ Includes coverage for Autism Spectrum Disorder.
Preventive Exams and Screenings	▪ Most preventive care covered at 100% in-network; 60% out-of-network. ▪ Age restrictions may apply.
Skilled Nursing Facility	▪ Covered at 80%; 180-day limit, additional days covered at 60% for both in- and out-of-network.
Urgent Care	▪ $30 copay in-network; $35 copay out-of-network. ▪ Covered at 80% in-network; 60% out-of-network.

[1] Plan pays 60% of Ohio Med PPO's contracted allowable amount and you pay any remaining balance.
[2] For prescription drug out-of-pocket cost information, see chart on Page 11.
[3] If your out-of-network charge is greater than the Ohio Med PPO contracted allowable amount, your out-of-pocket costs will be more.
[4] For a list of immunizations paid at 100 percent, see Page 10.
[5] Hearing aids for natural hearing loss are covered at 50%, up to $1,000 lifetime maximum.

FULL-TIME EMPLOYEE MEDICAL DEDUCTIONS

	FULL-TIME / BIWEEKLY PAID EMPLOYEE DEDUCTIONS[1]			FULL-TIME / MONTHLY PAID EMPLOYEE DEDUCTIONS[1]		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$46.19	$260.64	$306.83	$100.07	$564.75	$664.82
Family Minus Spouse	$126.44	$715.40	$841.84	$273.94	$1,550.02	$1,823.96
Family Plus Spouse[2]	$132.21	$715.40	$847.61	$286.44	$1,550.02	$1,836.46

[1] These rates represent the total amount that will be deducted from your paycheck.

[2] Family Plus Spouse rates above include a charge of $12.50 per month to cover a spouse.

PART-TIME EMPLOYEE MEDICAL DEDUCTIONS

	PART-TIME BIWEEKLY DEDUCTIONS[1] 50% TIER			PART-TIME BIWEEKLY DEDUCTIONS[1] 0% TIER		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$153.41	$153.42	$306.83	$306.83	$0.00	$306.83
Family Minus Spouse	$420.92	$420.92	$841.84	$841.84	$0.00	$841.84
Family Plus Spouse[2]	$426.69	$420.92	$847.61	$847.61	$0.00	$847.61

[1] These rates represent the total amount that will be deducted from your paycheck.

[2] Family Plus Spouse rates above include a charge of $12.50 per month to cover a spouse.

Preventive Care

STAY HEALTHY, SAVE MONEY

Preventing and detecting disease early is important to living a healthy life. The better your health, the lower your health care costs are likely to be. One of the most important actions you can take for your health and your family's health is to schedule regular check-ups and screenings with your primary care physician.

Your State of Ohio medical plan offers the following services with no deductible, no copayment and no coinsurance for network providers. Other services are available for the normal copayment, coinsurance and deductible amounts.

FREE EXAMS AND SCREENINGS	
Clinical breast exam	1/plan year
Colonoscopy	Every 10 years starting at age 50
Flexible sigmoidoscopy	Every 10 years starting at age 50
Glucose	1/plan year
Gynecological Exam	1/plan year
Hemoglobin, hematocrit or CBC	1/plan year
Lipid profile or total and HDL cholesterol	1/plan year
Mammogram	1 routine and 1 medically necessary/plan year
Pre-natal office visits	As needed; based on physician's ability to code claims separately from other maternity-related services
Stool for occult blood	1/plan year
Urinalysis	1/plan year
Well-baby, well-child exam	Various for birth to 2 years; then annual to age 21
Well-person exam (annual physical)	1/plan year

FREE IMMUNIZATIONS	
Diphtheria, tetanus, pertussis (DTap)	2/4/6/15-18 months; 4-6 years
Haemophilus influenza b (Hib)	2/4/6/12-15 months
Hepatitis A (HepA)	2 doses between 1-2 years
Hepatitis B (HepB)	Birth; 1-2 months; 6-18 months
Human Papillomavirus (HPV)	3 doses for 9-26 years
Influenza	1/plan year
Measles, mumps, rubella (MMR)	12-15 months, then at 4-6 years; adults who lack immunity
Meningococcal (MCV4)	1 dose between 11-12 years or start of high school or college
Pneumococcal	2/4/6 months; 12-15 months; annually at age 65 and older; high risk groups
Poliovirus (IPEV)	2 and 4 months; 6-18 months; 4-6 years
Rotavirus (Rota)	2/4/6 months
Tetanus, diphtheria, pertussis (Td/Tdap)	11-12 years; Td booster every 10 years, 18 and older
Varicella (Chickenpox)	12-15 months; 4-6 years; 2 doses for susceptible adults
Zoster (shingles)	1 dose for age 19 and older

This is not an all-inclusive list. Please refer to das.ohio.gov/medical for more information about preventive care services.

Prescription Drug

OptumRx provides prescription drug benefits for State of Ohio employees and their dependents who are enrolled in the Ohio Med PPO Plan.

Not all drugs are covered

Some drugs require the use of alternative medications before being approved. This is known as "step therapy." Examples include medications used for heartburn, glaucoma, multiple sclerosis, diabetes, asthma, elevated triglycerides, migraines, osteoporosis, nasal allergies, sleep disturbances and high blood pressure as well as atypical antipsychotics and antiviral medications such as Valtrex®. Additional medications requiring step therapy may be added at any time. If this occurs, members currently using the affected drugs will be notified in advance by mail.

A program description and a list of medications are on the Benefits Administration website, *das.ohio.gov/prescriptiondrug*, under **"Prescription Drug Updates."**

Diabetes Management Program

Members are eligible for free medication and diabetic supplies if they have had a hemoglobin A1C test within the past 12 months of being a member of the Ohio Med PPO.

Website offers online tracking, tools

The website for OptumRx, *OptumRx.com*, is a private, secure website. All of your pharmacy plan information is available at your fingertips 24/7.

Easy access to the OptumRx website allows you to:

- Compare mail-order prices and prices at local pharmacies;
- Find your lowest copay;
- Locate your pharmacy and get driving directions;
- Manage your mail-order prescriptions, including options to request a refill or track an order; and
- Learn more about your prescription drugs.

Visit *OptumRx.com* today. You will need your pharmacy member ID number located on your OptumRx card to log in. The number begins with the letter "A." For questions, contact OptumRx at 866-854-8850.

Specialty drug management program

Some specialized medications for serious medical conditions such as cancer, cystic fibrosis and rheumatoid arthritis must be obtained from the specialty pharmacy, Briova, and can only be filled for 30 days or less. Your order may be shipped to your home or workplace. A description of the program and a list of specialty medications are available on the Benefits Administration website at *das.ohio.gov/prescriptiondrug* under the **"Specialty Drug List."**

COPAYMENT COSTS

TYPE OF MEDICATION	30-DAY SUPPLY AT RETAIL COPAYMENT	30-DAY SUPPLY SPECIALTY COPAYMENT	90-DAY SUPPLY AT RETAIL COPAYMENT	90-DAY SUPPLY AT MAIL-ORDER COPAYMENT
Generic	$10	$10	$30	$25
Preferred Brand-Name	$25	$25	$75	$62.50
Non-Preferred Brand-Name, Generic Unavailable	$50	$50	$150	$125
Non-Preferred Brand-Name, Generic Available	$50 plus the difference between the cost of the brand-name and generic drug	$50 plus the difference between the cost of the brand-name and generic drug	$150 plus the difference between the cost of the brand-name and generic drug	$125 plus the difference between the cost of the brand-name and generic drug
Out-of-Pocket Maximum*	$2,500 single/$5,000 family			

The amount charged to the individual for generic, preferred brand and non-preferred brand medications will not be greater than the actual cost of the medication. Therefore, the amount charged may be less than the flat-dollar copay.

The maximum copay for oral oncology medications will be $100 for a 30-day supply. For more details, visit das.ohio.gov/prescriptiondrug.

* Pharmacy copays do not apply toward medical/behavioral health plan deductibles and the annual out-of-pocket maximum.

Behavioral Health

HELP AVAILABLE 24/7

Optum Behavioral Solutions provides specialized behavioral health and substance use services for State of Ohio employees and their dependents who are enrolled in the Ohio Med PPO. This program provides 24-hours-a-day, seven-days-a-week confidential phone assessment and referral services for a variety of behavioral health issues, such as:

- Anger management;
- Anxiety;
- Compulsive disorders;
- Depression;
- Marital and family issues;
- Serious mental illness;
- Stress; and
- Substance use disorders.

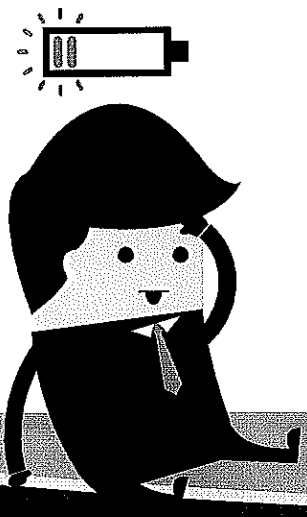
Copayments, deductibles and co-insurance are combined with your medical plan. If you receive behavioral health services prior to meeting your deductible, you may need to pay for these services up to the deductible amount before your plan starts paying. This does not apply to routine office visits for which you only pay an office visit copayment.

Benefits

Enrolled employees and their dependents have access to both in-network and out-of-network behavioral health benefits. However, you will pay more if you do not use a participating network provider and facility. This is known as balance billing. See the chart on this page for further details.

Support Services

The State of Ohio offers support services through the Ohio Employee Assistance Program (OEAP) for various behavioral health issues, which include behavioral health referrals and consultations for employees and their dependents. Other services include training, critical incident stress management, organizational transition interventions, mediation and a new Family Support Program for dependents up to age 26 who have a substance use problem. For details, visit *das.ohio.gov/behavioralhealth*.



BEHAVIORAL HEALTH BENEFIT PLAN	
Copayments	▪ Outpatient office visit in-network: $20
	▪ Outpatient office visit: out-of-network $30 (balance billing applies)
	▪ Intensive outpatient care in-network: $20
	▪ Intensive outpatient care out-of-network: $30 (balance billing applies)
Deductibles	▪ Single in-network: $250 combined with medical
	▪ Family in-network: $500 combined with medical
	▪ Single out-of-network: $500 combined with medical
	▪ Family out-of-network $1,000 combined with medical
Plan Coinsurance %	▪ Outpatient in-network: 100% after office visit copay, 80% for other services
	▪ Outpatient out-of-network: 60% of fee schedule after copayment (balance billing applies)
	▪ Inpatient in-network: 80% after deductible
	▪ Inpatient out-of-network: 60% after deductible, $350 penalty if not preauthorized
Out-Of-Pocket Maximum	▪ Single in-network: $1,500 combined with medical
	▪ Family in-network: $3,000 combined with medical
	▪ Single out-of-network: $3,000 combined with medical
	▪ Family out-of-network: $6,000 combined with medical
Other	▪ Day limits: None
	▪ Annual limits: None
	▪ Lifetime limits: None
	▪ Benefits limits: Some For details, visit *das.ohio.gov/behavioralhealth*, click the **Summary Plan Descriptions** tab and click the current summary plan.

Make Wellness Your Priority

LET *TAKE CHARGE! LIVE WELL!* BE YOUR GUIDE

Your health and wellness is important to us. The State of Ohio offers a robust and comprehensive health and wellness program called *Take Charge! Live Well!*

Take Charge! Live Well! provides the tools, guidance and resources you need to be healthier, happier and more productive, while reducing health care costs.

At an enterprise level, *Take Charge! Live Well!* is designed to:

- Offer preventive care tools and resources to its enrolled members and spouses;
- Increase productivity;
- Encourage engagement among employees and spouses;
- Improve retention; and
- Contain or reduce health care costs by improving health.

On a personal level, the benefits of *Take Charge! Live Well!* include:

- Biometric screenings;
- Well-Being 5 Survey;
- Health coaching;
- Rewards for taking steps to improve your health;
- 24-hour Nurse Advice Line;
- Flu vaccinations;
- Health and wellness fairs;
- Weight-loss, fitness and additional wellness challenges;
- A website full of resources, *ohio.gov/tclw*;
- On-site wellness ambassadors to provide information and answer questions; and
- Financial Well-Being program by financial expert Dave Ramsey.

Specific programs include:

- Tobacco cessation; and
- Support for chronic disease management.

Take Charge! Live Well! supports you in your effort to be your healthiest by helping you identify risks and improve your health.

Employees active in *Take Charge! Live Well!* appreciate the educational and motivational approach to health and wellness.

For full details, visit the *Take Charge! Live Well!* website at: *ohio.gov/tclw*.

WELLNESS REWARDS

Enrolled employees and spouses may earn up to $350 each by taking steps to improve their health

Level 1: Assess Your Health	Point Value
Earn up to $150 per person in Level 1	
Biometric screening: • Complete an on-site screening; or • Submit the Physician Form, which is to be completed by your physician.	100 Points
Complete your Well-Being 5 survey.	50 Points

Level 2: Take Action	Point Value
Earn up to $200 in Level 2 Points can be earned by completing up to four total actions within the same activity or by combining actions with multiple activities.	
Coaching Calls	Earn 50 points for each completed coaching call, up to four calls.
Well-Being Challenges	Earn 50 points for each completed challenge, up to four challenges.
Financial Well-Being	Earn 50 points for each completed Financial Well-Being lesson, up to four lessons.

Reward cards are taxable compensation. Taxes are based on the amount of your reward and will be deducted from your paycheck.

For details about rewards and the *Take Charge! Live Well!* program, go to the *Take Charge! Live Well!* program website, *ohio.gov/tclw*, and click on the **Program Guide** button.

Healthways Website Updates Scheduled

Healthways will be performing annual system updates from July 1 through 17. During this time, Well-Being Connect will not be accessible.

Dental and Vision
FOR EXEMPT EMPLOYEES

The State of Ohio pays the full cost for you and your eligible dependents (children younger than age 23[1]) to participate in the dental and vision plans. Exempt employees are eligible to participate in these plans effective the first day of the month after completing one year of continuous state service. Employees are sent a letter indicating when they will be eligible for dental coverage.

Delta Dental PPO

Dental coverage is offered through the Delta Dental PPO plan, offered through Delta Dental of Ohio. You can go to any licensed dentist of your choice and receive benefits, but you typically will pay less when you go to an in-network dentist.

Your out-of-pocket expenses will vary depending on the participation status of your dentist. Your out-of-pocket costs are likely to be lower if you go to a dentist who participates in one of the Delta Dental networks. For most covered services, Delta Dental pays a higher percentage if you go to a dentist in its PPO network over its Premier network. Delta pays the least for out-of-network dentists.

To find a participating Delta Dental dentist near you, visit or call:

deltadentaloh.com
800-524-0149
Group Number: 9273-0001

Print Your Delta Dental Card Online
If you would like a card to present to your dentist, you may print a card from Delta Dental's website. After you are enrolled in the dental plan, visit *deltadentaloh.com* and click on **Consumer Toolkit**.

Complete the login process and click on **Print ID Card**. If you are enrolling in the plan for the first time, please wait until July 1 to access the dental site.

Vision Service Plan

Vision coverage is offered through Vision Service Plan (VSP). The VSP Choice network encompasses a large number of providers. If you use a non-network provider, out-of-network charges will apply.

To find a participating VSP vision provider near you, visit or call:

vsp.com
800-877-7195
Group Number: 12022518

Print Your VSP Card Online
If you would like an enrollment card to present to your vision provider, you may print a card through the VSP website. After you are enrolled in the vision plan, visit *vsp.com*, complete the login process and click on **My Member Vision Card**. If you are enrolling in the vision plan for the first time, wait until July 1 to access the site.

See Page 15 to view the in-network and out-of-network benefits for the dental and vision plans.

[1] View detailed eligibility and documentation requirements at: *das.ohio.gov/EligibilityRequirements.*

UNION BENEFITS TRUST

For Union-Represented Employees

Union-represented employees receive dental, vision, life and legal plan benefits through Union Benefits Trust (UBT).

The UBT Enrollment Guide will be mailed to union members' homes. The guide includes enrollment/change forms for dental, vision and legal plans. For supplemental life insurance, a separate mailing from Prudential will arrive during the same period. For more information, please visit *benefitstrust.org.*

DELTA DENTAL PLAN FOR EXEMPT EMPLOYEES

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Delta Dental Dentist*
Annual Maximum	$1,500	$1,500	$1,500*
Diagnostic and Preventive Services	100%	100%	100%*
Basic Restorative Services (e.g., fillings)	100%	65%	65%*
Major Restorative Services (e.g., crowns, bridges)	60%	50%	50%*
Orthodontia	50% up to $1,500 lifetime maximum	50% up to $1,500 lifetime maximum	50% up to $1,500* lifetime maximum

Deductible – $25 deductible per person total per benefit year. The deductible does not apply to diagnostic and preventive services, emergency palliative treatment, X-rays, periodontal maintenance (cleaning) and orthodontic services.

There is a separate $1,000 lifetime maximum on dental implants.

*Delta Dental will pay up to the allowed amount or the maximum allowable charge for providers in your area. You can be balance billed by non-Delta Dental providers for any amount that exceeds the allowable amount. Network providers cannot balance bill you for the difference between their charge and Delta Dental's allowed amount.

VISION SERVICE PLAN (VSP) FOR EXEMPT EMPLOYEES

Service	In-Network	Out-Of-Network
Routine Exam/Frame/ Lens Frequency	1 every 12 months	
Routine Exam/ Professional Fees	Plan pays 100% after $10 copay.	You pay $10 copay, then plan pays maximum of $25.
FRAMES	Plan pays 100% up to $120 retail.	Plan pays maximum benefit of $18.
MATERIALS/LENSES Single Vision Lenses Bifocal Lenses Progressive Lenses Trifocal Lenses Lenticular Lenses Polycarbonate Lenses	Plan pays 100% after $15 copay.	You pay $15 copay, then plan pays maximum benefit of: $25 $35 $52 $52 $62 $0
CONTACT LENSES Elective (Instead of Lenses and Frames)	Plan pays maximum of $125 plus standard eye exam.	
Medically Necessary	Plan pays 100% plus standard eye exam.	Plan pays maximum of $125 plus standard eye exam.

Life Insurance
FOR EXEMPT EMPLOYEES

Exempt Basic Life Insurance

The State of Ohio pays the cost for eligible exempt employees to participate in the basic life plan. Eligible exempt employees are automatically enrolled in the basic life plan after one year of continuous state service. The coverage includes an accidental death and dismemberment benefit for work-related injuries. This benefit – equal to your annualized rate of pay rounded to the next highest $1,000 – is provided to you at no cost.

The Internal Revenue Service (IRS) requires that employees be taxed on the value of employer-paid group life insurance coverage exceeding $50,000. This is known as "imputed income." If your annualized rate of pay (and thus your group life insurance) exceeds $50,000 per year, the tax you owe on the value of the coverage that exceeds $50,000 is reported to the IRS in Box 12 of your year-end W-2 form. The tax is based upon employee age brackets on the last day of the calendar year and increases in five-year increments as you grow older. See the imputed income rate chart on the right.

IRS BASIC LIFE IMPUTED INCOME CHART
(Monthly Cost Per $1,000 of Coverage in Excess of $50,000)

AGE	COSTS
Younger than 25	$0.05
25 through 29	$0.06
30 through 34	$0.08
35 through 39	$0.09
40 through 44	$0.10
45 through 49	$0.15
50 through 54	$0.23
55 through 59	$0.43
60 through 64	$0.66
65 through 69	$1.27
70 and older	$2.06

Beneficiary Forms

You may designate one or more beneficiaries for your basic and supplemental life benefits by visiting the Minnesota Life, a Securian company, website at lifebenefits.com. For logon instructions, see Page 17 under Life Insurance for exempt employees. Or you may submit a beneficiary form by mail to Minnesota Life. This form is available in the forms section of the DAS Benefits Administration website, located at *das.ohio.gov/HealthPlanForms*. Your beneficiary elections will apply to both your basic and supplemental life insurance benefits.

Exempt Supplemental Life Insurance

Exempt employees are eligible to purchase supplemental life insurance coverage, provided by Minnesota Life. This coverage is entirely employee-paid, and can be purchased within 90 days of employment or upon becoming an exempt employee with no waiting period. When you enroll for coverage, you also may elect life insurance for your eligible dependents. The amount you contribute toward your supplemental and dependent life coverage is deducted from your paycheck. See Page 17 for plan contact information and initial logon credentials.

For Yourself

At Open Enrollment, if you do not already have supplemental life coverage, you may purchase up to the lesser of two times your annualized earnings or $150,000 without evidence of insurability. If you have existing coverage, you may increase coverage by up to the lesser of two times your annualized earnings or $150,000 without evidence of insurability.

The maximum amount of coverage available is the lesser of eight times your annualized earnings or $600,000. If your coverage election exceeds the non-medical limits described above, evidence of insurability will be required. Coverage above the non-medical limits will become effective once evidence of insurability is approved by Minnesota Life. Outside of Open Enrollment, supplemental life coverage may not be increased without a qualifying life event. If you experience a qualifying life event, you must submit your request within 31 days of the associated life event. For questions regarding a qualifying life event, call Minnesota Life. See Page 17 for contact information.

For Your Spouse

You may purchase supplemental life insurance for your spouse in $10,000 increments up to $40,000. Spousal coverage in excess of $10,000 requires your spouse to provide evidence of insurability.

For Your Dependent Children

You may purchase $7,000 of life coverage for each of your eligible dependent children younger than age 26 at a rate of $0.82 cents per month, regardless of how many children you cover. You are responsible for dropping your dependent's coverage when your child reaches age 26.

Cancelling or Reducing Coverage

You may cancel or reduce your employee or dependent supplemental life insurance coverage at any time throughout the year by submitting a written request to Minnesota Life. Coverage will be cancelled or reduced effective the first of the month after your request is received and processed by Minnesota Life. Once coverage is cancelled or reduced for either yourself and/or your dependents, evidence of insurability will be required for any future enrollment for supplemental life coverage, including during Open Enrollment and qualifying life events. You may be required to submit medical documentation and your coverage election may be approved or rejected by Minnesota Life based upon medical underwriting results.

Health and Other Benefits Contacts

ALL EMPLOYEES

Medical
Aetna
800-949-3104
aetnastateohioemployee.com
Group Number: 285507

Anthem
844-891-8359
enrollment.anthem.com/stateofohio
Group Number: 004007521

Medical Mutual of Ohio
800-822-1152
stateofohio.medmutual.com
Group Number: 228000

Prescription Drug
OptumRx
866-854-8850
OptumRx.com
Rx Group Number: STOH

Behavioral Health and Substance Use
Optum Behavioral Solutions
800-852-1091
liveandworkwell.com
Website Access Code: 00832

Ohio Employee Assistance Program
800-221-6327
ohio.gov/eap

Take Charge! Live Well!
Healthways
866-556-2288
ohio.gov/tclw
Click the Healthways website button.

24-Hour Nurse Advice Line
Healthways
866-556-2288, option 1

Flexible Spending Accounts and Commuter Choice
WageWorks
855-428-0446
wageworks.com

EXEMPT EMPLOYEES ONLY

Dental
Delta Dental of Ohio
800-524-0149
deltadentaloh.com
Delta Dental PPO
Group Number: 9273-0001

Vision
Vision Service Plan (VSP)
800-877-7195
vsp.com
Group Number: 12022518

Life Insurance
Basic Life Insurance and Supplemental Life Insurance
Minnesota Life, a Securian company
866-293-6047
lifebenefits.com
Group Number: 34301
Initial logon credentials for life insurance: The initial user ID is "**OH**" plus your State of Ohio User ID. The initial password is your date of birth (MMDDYYYY) plus the last four digits of your Social Security number.

Ohio Department of Administrative Services

HR Customer Service

614-466-8857 (option 2) or
800-409-1205 (option 2)

email: *HRCustomerService@das.ohio.gov*

website: *das.ohio.gov/benefits*

TIP:

When placing a call, please ensure you have the documentation you might need during the call:

- Group Number
- State of Ohio User ID
- Explanation of Benefits if call is regarding a claim.

UNION-REPRESENTED EMPLOYEES ONLY

Union Benefits Trust
614-508-2255
800-228-5088
benefitstrust.org

The websites of the Union Benefits Trust (UBT) vendors listed below can be accessed through the UBT website.

Dental
Delta Dental of Ohio
877-334-5008
Group Number: 1009

Vision
Vision Service Plan (VSP)
800-877-7195
Group Number: 12022914

EyeMed Vision Care
866-723-0514
Group Number: 9674813

Life Insurance
Prudential Life Insurance
800-778-3827
Group Number: LG-01049

Work/Life Program
Working Solutions Program
800-358-8515
Group Number: 4718

Legal Services
Hyatt Legal Services
800-821-6400
Group Number: 4900010

UNION BENEFITS TRUST

Legal Notices

State of Ohio
Employee Health Plans
30 E. Broad St., 27th Floor
Columbus, Ohio 43215

NOTICE OF PRIVACY PRACTICES

Effective April 1, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes the privacy practices of the State of Ohio's self-funded medical plans, prescription drug plan, behavioral health plan, population health management plan, dental plans, vision plans, flexible spending account (but not dependent care flexible spending account) which are administered by the State of Ohio, Department of Administrative Services, Office of Benefits Administration Services (collectively "the Plan"). The Plan is required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information (PHI), and to provide individuals with notice of the legal duties and privacy practices with respect to protected health information and to abide by the terms of the notice currently in effect.

Position on Privacy

The Plan is committed to maintaining the privacy of its enrolled persons. As part of your participation in the health plans, the Plan and its business associates (whom we use to administer and deliver health care services) receive health information through the operation and administration of the plans. PHI refers to any information, transmitted or maintained in any form or medium, which the Plan creates or receives that relates to your physical or mental health, the delivery of health care services to you or payment for health care services that identifies you or could reasonably be used to identify you. PHI and other Plan records are maintained in compliance with applicable state and federal laws.

If you have questions about this notice, please contact the Plan's HIPAA Privacy Contact listed on Page 20.

How the Plan May Use or Disclose Your Protected Health Information

The Plan may only use or disclose your medical information as described in this notice. Not every authorized use or disclosure in each category is listed, however all permitted uses and disclosures fall into one of these general categories.

1. Uses and Disclosures of Your PHI for Treatment, Payment, and Health Care Operations

For Treatment. The Plan may make requests, uses, and disclosures of your PHI as necessary for treatment purposes. For example, the Plan may make disclosures to your health plan regarding eligibility, or make disclosures to health care professionals involved in your care.

For Payment. The Plan may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, the Plan may use information regarding your medical procedures and treatment so the third party administrator can process and pay claims. The Plan may also disclose your PHI for the payment purposes of a health care provider or a health plan.

For Health Care Operations Purposes. The Plan may use and disclose your PHI as necessary for health care operations. For example, Health Care Operations include, but are not limited to, use and disclosures: by health plan of PHI to the Plan for administration of the health plans; for quality assessment of the plans through the distribution and analysis of satisfaction surveys; in connection with the performance of disease management functions; and for general administrative activities, including customer service, cost management, data management, communications, claims and operational audits, and legal services. In addition, a health plan may send you information based on your own health information to inform you of possible treatment options or alternatives that may be available to you. The Plan may also combine your health information with that of other enrolled persons to evaluate the coverage provided and the quality of care received.

2. Other Uses and Disclosures of PHI for Which Your Authorization is Not Required

In limited instances, the law allows the Plan to use and disclose your PHI without your authorization in the following situations:

A. **As Required By Law.** The Plan may disclose your PHI when required by federal, state or local law.

B. **Family and Individuals Involved in Your Care.** The Plan may disclose medical information about you to a family member or friend who is involved in your medical care. The Plan may request that your family members verify their identity and demonstrate they are acting on your behalf.

C. **To Avert a Serious Threat to Health or Safety.** The Plan may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public.

D. **Public Health Activities.** The Plan may use and disclose medical information about you for public health activities including activities related to preventing and controlling disease or, when required by law, to notify public authorities concerning cases of abuse or neglect.

E. **Victims of Abuse, Neglect, or Domestic Violence.** The Plan may disclose medical information to a government authority, including a social service or protective agency if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence.

F. **Health Oversight Activities.** The Plan may disclose medical information to a health oversight agency for oversight activities authorized by law, such as: overall health care system monitoring, monitoring the conduct of government programs, and monitoring to ensure compliance with civil rights laws.

G. **Lawsuits/Legal Disputes.** The Plan may use and disclose medical information about you in the course of an administrative or judicial proceeding, such as in response

to a subpoena, discovery request, warrant, or a lawful court order.

H. **Law Enforcement Purposes.** The Plan may disclose medical information to law enforcement officials for law enforcement purposes including investigation of a crime or to identify or locate a suspect, fugitive, material witness or missing person.

I. **Specialized Government Functions.** The Plan may disclose medical information to authorized federal officials for the purposes of intelligence, counterintelligence, and other national security activities authorized by law.

J. **Military.** If you are a member of the armed forces, the Plan may disclose medical information about you as required by military command authorities.

K. **Organ, Eye and Tissue Donation.** If you are an organ donor, the Plan may disclose information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

L. **Workers' Compensation.** The Plan may disclose medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

M. **Coroners, Medical Examiners, and Funeral Directors.** The Plan may disclose medical information to a coroner or medical examiner to, for example, identify a deceased person or determine the cause of death. The Plan may also disclose medical information about patients to funeral directors as necessary to carry out their duties.

N. **Business Associates.** The State contracts with parties who provide necessary services for the operation of its plans. For example, the Plan is assisted in its operations by third party administrators. These persons who assist the Plan are called business associates. At times, the Plan may use and disclose PHI so they can provide services. The Plan will require that any business associates who receive PHI safeguard the privacy of that information.

O. **Disclosure to You.** The Plan may disclose your medical information to you.

3. Other Uses and Disclosures of PHI Requiring Your Written Authorization

In all situations other than those described previously, the Plan will ask for your written authorization before using or disclosing your PHI. For example, (except as required or permitted by law), the Plan will not use or disclose psychotherapy notes or sell your medical information without obtaining your prior written authorization. If you have provided authorization, you may revoke it in writing at any time, unless the Plan has already disclosed the information.

4. Changes to Existing Laws

Certain provisions of Ohio law may impose greater restrictions on uses and/or disclosures of PHI, or otherwise be more stringent than federal rules protecting the privacy of PHI. If such provisions of Ohio law apply to a use or disclosure of PHI or under other circumstances described in this notice, the Plan must comply with those provisions.

Your Legal Rights

Federal privacy regulations provide you the following rights associated with your medical information:

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. (For example, you could ask that the Plan not disclose or use information about a certain medical treatment you received.) **The Plan is not required to agree to your request.** To request restrictions on the use or disclosure of your PHI, you must make your request in writing to the Plan's HIPAA Privacy Contact listed on Page 20. In your request, you must explain: (1) what PHI you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and, (3) to whom you want the limits to apply (for example, your spouse).

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at a specific phone number or address. To request confidential communications, you must make your request in writing to the Plan's HIPAA Privacy Contact listed on Page 20. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. After the Plan receives your request, the information may be forwarded to your health plan. As a result, additional reasonable information may be required from you by your plan to process the request.

Right to Inspect and Copy Your Information. You have the right, in most cases, to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Plan's HIPAA Privacy Contact listed on Page 20. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing, or other unusual supplies associated with your request. Under Ohio and federal law, the Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Request an Amendment. If you feel that medical information about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Plan's HIPAA Privacy Contact listed on this page. You must provide reasons that support your request. If the Plan denies your request for any reason under state or federal law, the Plan will permit you to submit a written statement of disagreement to be kept with your PHI. The Plan may reasonably limit the length of such statement of disagreement.

Legal Notices

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures the Plan has made of medical information about you. This accounting will not include many routine disclosures including, but not limited to, those made to you or pursuant to your authorization, those made for treatment, payment and operations purposes as discussed above, those made for national security and intelligence purposes, and those made to law enforcement in compliance with law.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan's HIPAA Privacy Contact. Your request must state the time period that may not be longer than six (6) years prior to the date on which the accounting is requested. Your request should indicate in what form you want the list (paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice even if you have received it electronically. You may make your request to the Plan's HIPAA Privacy Contact.

Right to Breach Notification. You have the right to notification if a breach of your unsecured PHI has occurred.

This Notice Is Subject To Change

The Plan reserves the right to change the terms of this notice and its privacy practices at any time. If such a change is made, the new terms and policies will be effective for all of the information that the Plan has about you as well as any information it may hold about you in the future, and will be posted at das.ohio.gov and may be provided by mail if required. If you want to ensure you have the latest version of this notice, you may contact the Plan's HIPAA Privacy Contact.

Whom to Contact

If you believe your privacy rights have been violated, you may file a complaint with the Plan's HIPAA Privacy Contact or with the Secretary of the Department of Health and Human Services.

To file a complaint with the Secretary of the U.S. Department of Health and Human Services, contact the

Office of Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601.

Complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

Questions regarding this Notice may be directed to the Plan's HIPAA Privacy Contact:

DAS -- HIPAA Privacy Contact
30 East Broad St., 27th Floor
Columbus, Ohio 43215

614-466-6205; email: *gregory.pawlack@das.ohio.gov*

NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE

What is COBRA Continuation Coverage?

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. You, your spouse and dependent children, if any, should all take the time to read the entire notice carefully.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Legal Notices

**If a covered child of the employee is enrolled in the plan pursuant to a qualified medical child support order (QMCSO) during the employee's period of employment, he or she is entitled to the same rights under COBRA as if he or she were the employee's dependent.*

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employees is becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability: The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment.

To benefit from this extension, a qualified beneficiary must notify the Plan Administrator or designated Plan Service Provider of the disability determination on or before 60 days from the COBRA start date, and before the end of the original 18-month period. If you do not notify the Plan Administrator or the designated Plan Service Provider within the required period of time, you may lose your right to the extension.

The affected individual must also notify the Plan Administrator or designated Plan Service Provider within 30 days of any final disability determination that the individual is no longer disabled. Coverage will end on the first of the month, following at least 30 days after the date of the Social Security final disability determination letter.

Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Your Election Rights: When the Plan Administrator or designated Plan Service Provider is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage (because of one of the events described above) to inform the Plan Administrator or the designated Plan Service Provider that you want continuation coverage. If you do not choose continuation coverage in a timely manner, your group health insurance coverage will end.

Coverage Rights: If you choose continuation coverage, the Plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. Each covered person will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Maximum Period of Coverage: The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment (for reasons other than gross misconduct) or reduction in hours. In that case, the required continuation coverage period is 18 months. These 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period. In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

Legal Notices

California State Residence: Under California law, you may be eligible for a state-mandated extension of benefits after your federally-mandated COBRA period expires. California state laws allow an extension of COBRA benefits to a total of 36 months from the date of your qualifying event to qualified beneficiaries who begin COBRA coverage on or after Jan. 1, 2003. You will be notified of this extension at the conclusion of your original COBRA coverage.

Flexible Spending Account or Medical Reimbursement Account: If you are participating in the company's Flexible Spending Account or Medical Reimbursement Account at the time of your termination or reduction of hours, you may also have the right to continue participation under COBRA based on the following parameters:

1. You will be allowed to continue coverage for the remainder of the current plan year if you have a balance remaining in your account at the time of your termination or reduction in hours;
2. You will not be able to receive reimbursements in excess of your original election amount in the account; and
3. You make monthly payments in the same amount as your regular payroll deductions while you were an active employee.

Adding Dependents to COBRA Coverage: A child who is born to or adopted by the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator or designated Plan Service Provider of the birth or adoption.

Expiration of COBRA Coverage: The law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The company no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered - after the date he or she elects COBRA coverage - under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Limits to Pre-Existing Conditions: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rules with these new limits as follows:

- If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.
- You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Insurance Premiums: Under the law, you may have to pay all or part of the premium for your continuation coverage. You may also be required to pay a 2% administration fee above the cost of the premiums. If you are disabled, you may be required to pay 150% of the premium during the 11-month extension period.

Grace Period: There is a grace period of 30 days for payment of the regularly scheduled premium.

Conversion Coverage: At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries may be allowed to enroll in an individual conversion health plan provided a conversion health plan is available to active employees. Please read your health plan benefits booklet or Summary Plan Description regarding any option for conversion coverage after the expiration of COBRA coverage. If there is an option for conversion to an individual policy, follow the instructions provided to apply for the coverage, as it would be separate coverage, and would not simply be an extension of COBRA coverage.

If You Have Questions

This notice does not fully describe continuation coverage or other rights under the Plan. More complete information regarding such rights is available from the plan contact identified on Page 20 and throughout the Summary Plan Description. Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified on Page 20. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act (PPACA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available on EBSA's website.) For more information about the Marketplace, visit *www.Healthcare.gov.*

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA contact information

If you have any questions about your rights to COBRA continuation coverage, you should contact:

Legal Notices

Through June 30, 2017:

UnitedHealthcare
P.O. Box 221709
Louisville, KY 40252

Customer Care Center
Toll Free: (877) 237-8576
email: *cobra_kyoperations@uhc.com*
www.uhcservices.com

Beginning July 1, 2017:
Visit das.ohio.gov/cobra for contact information.

SPECIAL ENROLLMENT RIGHTS PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage.

The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having other health insurance or group health plan coverage at the time of your eligibility to participate, you may enroll yourself or your dependents at a future point, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days of such an event.

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your Plan Administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at 312-353-0900.

If you have questions about this notice, please contact your Plan Administrator listed below:

State of Ohio
Department of Administrative Services
Benefits Administration Services
Medical Plan Benefits Manager

30 East Broad Street, 27th Floor
Columbus, Ohio 43215
(800) 409-1205 (option 2)

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. The terms of WHCRA provide:

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and,
4. Treatment of physical complications of all stages of mastectomy, including lymphedema.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

If you have any questions or would like more information about the State of Ohio's WHCRA benefits, contact HR Customer Service at 614-466-8857 (option 2) or 800-409-1205 (option 2).

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under the provisions of The Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PATIENT PROTECTION DISCLOSURE

The Ohio Med PPO generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, please see the contact numbers below for Aetna, Anthem, and Medical Mutual of Ohio.

Legal Notices

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Aetna, Anthem, Medical Mutual of Ohio, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact: Aetna at (1-800-949-3104); Anthem at (1-844-891-8359); or, Medical Mutual of Ohio at (1-800-822-1152).

CREDITABLE COVERAGE DISCLOSURE:

Important Notice from the State of Ohio About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State of Ohio and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- The State of Ohio has determined that the prescription drug coverage offered by OptumRx is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current State of Ohio coverage will not be affected. The State of Ohio has determined that the prescription drug coverage offered by OptumRx is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Go to: *das.ohio.gov/prescriptiondrug* for more details on your prescription benefits.

If you decide to join a Medicare Drug Plan and drop your current state medical coverage, be aware that you and your dependents will not be able to get this coverage back unless you experience a qualifying event or sign up during Open Enrollment.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the State of Ohio and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For further information, contact:

State of Ohio
Ohio Department of Administrative Services
Benefits Administration Services
Prescription Drug Benefits Manager

30 East Broad, 27th Floor
Columbus, OH 43215
800-409-1205 (option 2)

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the State of Ohio changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

Legal Notices

For more information about Medicare prescription drug coverage:

- Visit: *medicare.gov.*
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the Web at: *socialsecurity.gov* or call them at 1-800-772-1213 (TTY 1.800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

NOTICE REGARDING WELLNESS PROGRAM

Take Charge! Live Well! is a voluntary wellness program available to all employees enrolled in the State of Ohio medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You also will be asked to complete a biometric screening, which will include a blood test for total cholesterol, high density lipoprotein (HDL), low density lipoprotein (LDL), triglycerides, and blood glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to $50 for completion of the HRA and $100 for completion of a biometric screening. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives of up to $200 may be available for employees who participate in certain health-related activities such as health coaching and online participation in health and wellness lessons and/or challenges. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation. You may request a reasonable accommodation by contacting Beth Kim, State of Ohio Wellness program manager, at 614-728-5478.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching and QuitNet. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the State of Ohio may use aggregate information it collects to design a program based on identified health risks in the workplace, *Take Charge! Live Well!* will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the health coaching staff at Healthways, in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Beth Kim at 614-728-5478.

PLEASE NOTE: The material in this publication is for informational purposes. It is intended only to highlight the main benefits, eligibility policies and coverage information for State of Ohio employees and their dependents. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the plan documents, the plan documents govern. To locate the plan documents on the Benefits Administration website, *das.ohio.gov/benefits,* click on **Medical** located in the right navigation pane under Benefits.

Glossary

When reviewing information about your health care coverage options, it is helpful to understand some of the basic terms and concepts.

Benefit Year/Plan Year: The 12-month period from July 1 through June 30 during which services are rendered and your deductible and coinsurance are accumulated.

Biometric Screening: A private screening with a health professional that provides a snapshot of your health. The screening includes cholesterol (total), HDL, LDL, blood glucose, blood pressure, height, weight and waist circumference.

Change in Status/Qualifying Event: A change in your life that allows you to enroll or make an adjustment to your existing coverage. Examples include marriage, divorce, birth or adoption of a child, or a change in job status for you or a dependent.

Coinsurance: The percentage of eligible expenses that the health care plan pays after the annual deductible is met. For example, an 80 percent coinsurance rate means you pay 20 percent and the plan pays 80 percent.

Copay: A specified dollar amount you pay to a health care provider or pharmacy for eligible expenses such as office visits and prescriptions. Copays do not count toward your annual deductible.

Covered Person: The employee, the employee's spouse and/or dependent children who are eligible and enrolled under your health care plan.

Covered Services: Those services and supplies provided for the purpose of preventing, diagnosing or treating a medical condition, behavioral disorder, psychological injury or substance use addiction for which the plan will provide benefits.

Deductible: The amount you pay for eligible expenses each plan year before the plan begins to pay anything. This does not apply to preventive services covered at 100 percent.

Dependent(s): A spouse and/or an eligible child or children.

Eligible Expense: The maximum amount on which payment is based for covered health care services. You may be required to pay a percentage of Eligible Expenses in the form of Coinsurance.

Employee Share or Contribution: The portion of the total premium that you pay through pre-tax payroll deductions for your coverage.

Exempt Employee: An appointment to a position not represented by a labor union. Employees are usually exempt from union representation because they are supervisors, in positions of a confidential or fiduciary nature or not in permanent appointments.

Flexible Spending Accounts (FSA): A type of savings account that provides the account holder with specific tax advantages. The account allows employees to contribute a portion of his or her regular earnings to pay for qualified expenses, such as for medical or dependent care. The two types of FSAs are health care spending accounts and dependent care spending accounts.

Out-of-pocket Maximum: The cap or maximum amount you pay for eligible out-of-pocket health care expenses during the plan year. After your out-of-pocket expenses reach the maximum, the plan pays 100 percent of any additional eligible expenses for the remainder of the plan year. There is a separate out-of-pocket maximum for prescription drugs.

Patient Protection and Affordable Care Act (also known as the Affordable Care Act or PPACA or simply ACA): The health reform legislation passed by Congress and signed into law in March 2010 by the president of the United States.

Preferred Provider Organization (PPO): A PPO is a medical plan that offers benefits at both network and non-network levels. When you enroll in the Ohio Med PPO, you may visit any doctor and receive benefits. However, the benefit is greater when you use network providers, but less when you use providers who are not part of the network.

State Share or Contribution: The portion of the total premium the State of Ohio pays to provide its employees with coverage.

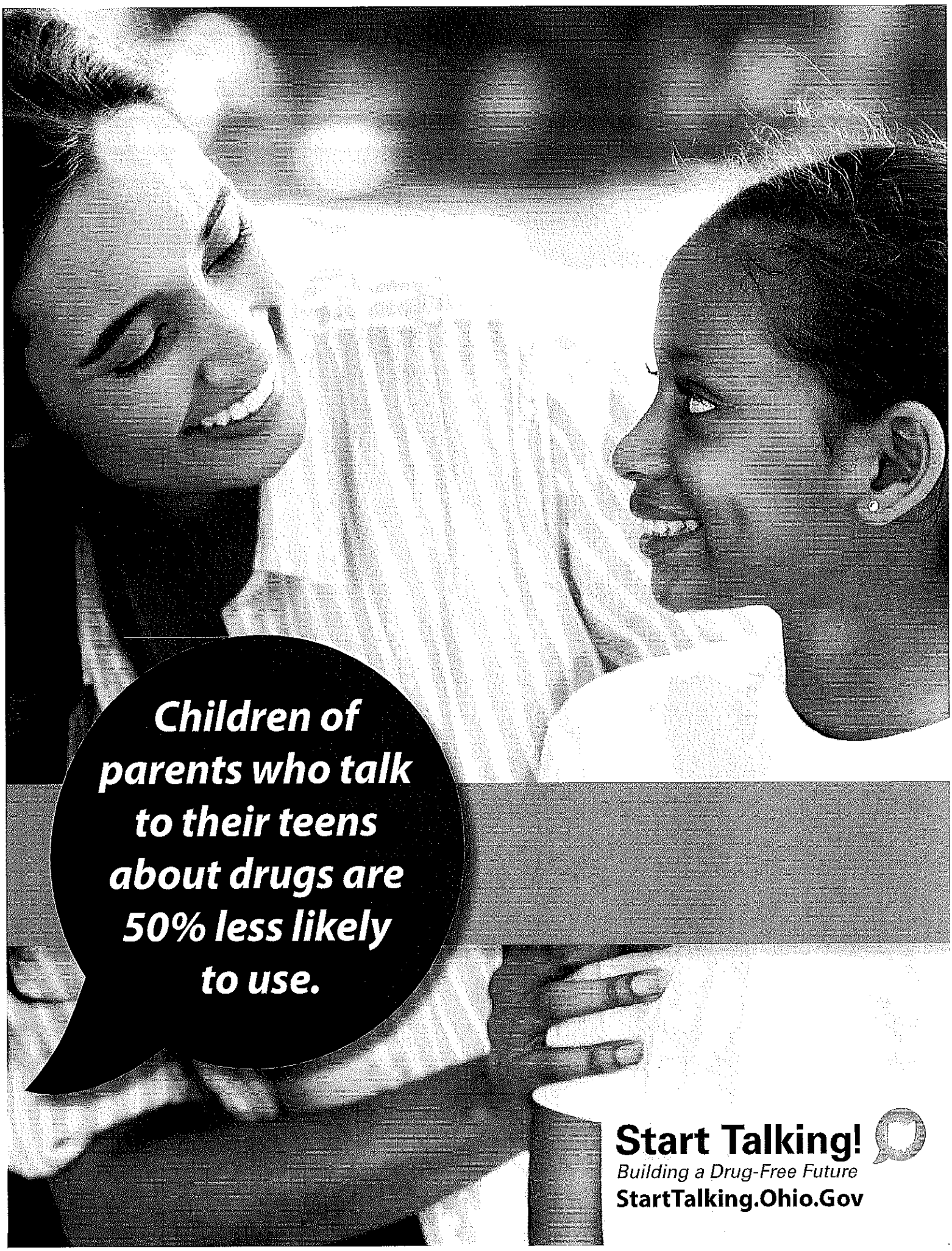
Summary of Benefits and Coverage (SBC): A requirement of the Patient Protection and Affordable Care Act, the SBC is a concise four-page document that details simple and consistent information about health plan benefits and coverage. It will help you understand the basics of your coverage and allow you to compare any different coverage options you may have. It summarizes the key features of the plan, such as covered benefits, cost-sharing provisions, and limitations and exceptions. All insurance companies and group health plans must use the same standard SBC form. The SBC also contains a link to the required Uniform Glossary, which provides definitions of many commonly used health coverage and medical terms. For full details, visit das.ohio.gov/benefits.

Third-Party Administrator (TPA): An organization or company that processes claims and other aspects of employee benefits plans on behalf of an employer. For example, Aetna, Anthem and Medical Mutual are the third-party administrators of the Ohio Med PPO.

Total Premium: The combination of the employee contribution and the state contribution.

Union-Represented Employee: Also known as a Bargaining Unit Employee, is represented by a labor union and covered by the terms of a collective bargaining agreement.

Well-Being 5 Survey: A confidential questionnaire that assesses your physical, emotional, financial and social health and how your lifestyle habits affect your overall well-being.


Children of parents who talk to their teens about drugs are 50% less likely to use.
Start Talking!
Building a Drug-Free Future
StartTalking.Ohio.Gov

OhioDAS
SERVICE · SUPPORT · SOLUTIONS
DEPARTMENT OF ADMINISTRATIVE SERVICES

Ohio Department of Administrative Services
Human Resources Division
30 E. Broad St., 28th Floor
Columbus, Ohio 43215

2017 OPEN ENROLLMENT

Open Enrollment 2017

MAY 15 THROUGH MAY 26, 2017

(EFFECTIVE JULY 1, 2017 THROUGH JUNE 30, 2018)

Ohio Med PPO Plan

- Three administrators will manage the Ohio Med PPO plan
  - Aetna
  - Anthem
  - Medical Mutual
  - The rate will be the same for all administrators
  - Employees will automatically be assigned to the correct administrator

Important Administrator Highlights

- Employee contributions- 'Family w/Spouse', 'Family w/o Spouse', and 'Single' rates will be the same with all administrators

- Major benefit levels- Co-pays, deductibles, and out-of-pocket maximums will be the same with all administrators

Medical Rates

- Rates are increasing

FULL-TIME EMPLOYEE MEDICAL DEDUCTIONS						
	FULL-TIME / BIWEEKLY PAID EMPLOYEE DEDUCTIONS[1]			FULL-TIME / MONTHLY PAID EMPLOYEE DEDUCTIONS[1]		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$46.19	$260.64	$306.83	$100.07	$564.75	$664.82
Family Minus Spouse	$126.44	$715.40	$841.84	$273.94	$1,550.02	$1,823.96
Family Plus Spouse[2]	$132.21	$715.40	$847.61	$286.44	$1,550.02	$1,836.46

[1] These rates represent the total amount that will be deducted from your paycheck.

[2] Family Plus Spouse rates above include a charge of $12.50 per month to cover a spouse.

Dependent Eligibility

- Dependents may receive medical coverage up to age 26
  - No student requirements
  - Dependents may be married
  - No financial or residency requirements for step children

Optum Rx Prescription Coverage

- ID Cards
  - All employees will receive new prescription cards from OptumRx

- Specialty medications
  - Specialty medications for serious medical conditions must be obtained from Briova Specialty Pharmacy.

- Preventative medications
  - Certain preventative medications are required to be covered at no charge. All of these require a prescription and may have certain quantity and/or age restrictions.

Behavioral Health

- Coverage is administered by Optum Behavioral Solutions
  - The plan provides 24-hours-a-day, seven-days-a-week phone assessment and referral services.

- All employees and dependents enrolled in the state's medical plan are eligible for behavioral health coverage
  - Participants can visit any provider, but will pay more for out-of-network providers and facilities.

Dental and Vision

- Only one dental and vision plan offered
  - Delta Dental PPO
  - Vision Service Plan (VSP)

- Dependent eligibility for dental and vision coverage is NOT the same as medical
  - Dependent children are eligible up to age 23
  - Student certification is required

- You do not have to be enrolled in medical coverage to enroll in dental and vision coverage

Take Charge! Live Well!

- Wellness program
  - Well-being assessment
  - Biometric screening

- Assistance programs
  - Weight loss management
  - Tobacco management
  - Diabetes management

Supplemental Life Insurance

- You can purchase coverage during the open enrollment period to supplement the basic life insurance coverage the state provides.
- Supplemental life insurance is administered by Minnesota Life Insurance Company and may be purchased through payroll deduction.
- Dependents may be covered until their 26th birthday.

Open Enrollment Website

- DAS has provided detailed information on their website for the 2017 Open Enrollment. Please click on the link below to access the site:

http://www.das.ohio.gov/OpenEnrollment

Questions?

- If you have additional questions regarding your benefits, contact Jason Parsons at 466-4308.